

The Modern Hospital

JUNE 1953

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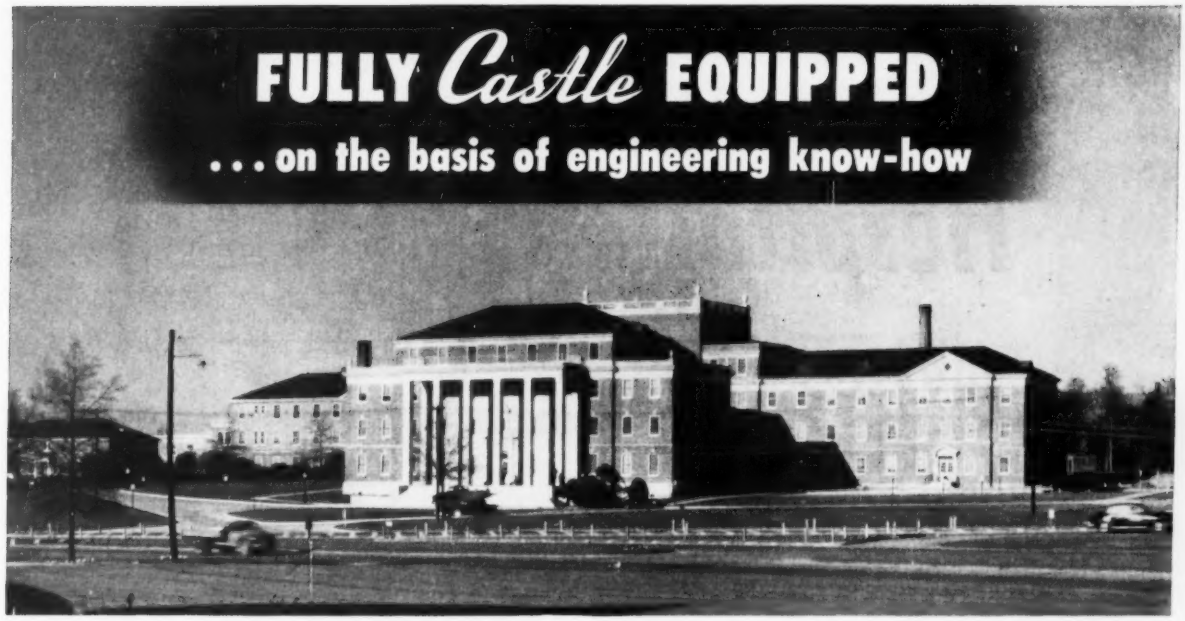
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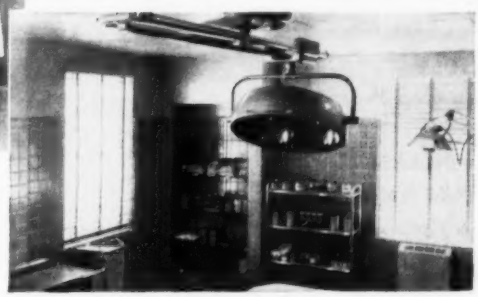


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The Modern Hospital

JUNE 1953

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ADMINISTRATION

Prototype Study: The 50 Bed Hospital — LOUIS BLOCK, Dr. P.H. — 51

Western Hospitals Get the Wright Treatment — 56

At Tri-State They Learned More in the Corridors — 57

The Modern Hospital of the Month — F. CARTER WILLIAMS — 59

Lest They Forget—Write It Down! — MARGARET HILL — 62

The Administrator Goes to Surgery — SAMUEL W. FRIEDMAN, D.D.S. — 63

Nurses From Abroad — MELVIN DUNN — 66

Pay Tomorrow's Bills Today — HARRY BECKER — 67

Orthopedics Comes Into Its Own — DAVID GOODMAN — 70

They Built a Hospital Around a Hospital — W. C. PERDEW — 71

The Strange Case of Dr. Loyal Davis — GREER WILLIAMS — 74

Untangle Those Lines of Authority! — PAUL J. GORDON — 77

Pavilion Manager — ANN J. DENNISON — 79

Clinical Photography Focuses on Teaching — WILLIAM A. KOZMA — 81

SMALL HOSPITAL FORUM

Tornado in Texas — 82

The Puzzle of the Paid Physicians — MICHAEL M. DAVIS — 83

Disaster Plan Works — SISTER MARY SYLVESTRE — 84

VOLUNTEER FORUM

How Auxiliaries Can Keep Pace — RHEA C. ACKERMAN — 86

MEDICINE AND PHARMACY

Four Phases of the Polio Problem:

1. Michael Reese Hospital's Over-All Plan — MORRIS H. KREEGER, M.D. — 90
2. Medical Management of Bulbar Cases — JAMES A. DOWNING, M.D. — 94
3. The Nurse's First Job: Establish Confidence — JACQUELYN COOK — 100
4. Make Room for Physical Therapy — LORETTO SULLIVAN — 106

Succinylcholine — NOTES AND ABSTRACTS — 108

FOOD AND FOOD SERVICE

Centralized or Decentralized Service? — MARIE-CLARE ROWBOTHAM — 114

How to Allocate Food Storage Space — JANE SEDGWICK PIRKEY — 116

Menus for July 1953 — SISTER M. DORIS — 120

MAINTENANCE AND OPERATION

N.F.P.A. Presents a Guide to Fire Safety — 122

HOUSEKEEPING

The V.A. Sets Up Housekeeping—Manual on Mopping—3 — 126

REGULAR FEATURES

Among the Authors — 4

Reader Opinion — 6

Roving Reporter — 10

Index of Advertisers — Following Page 16

Small Hospital Questions — 47

Wire From Washington — Following Page 48

Looking Around — 49

About People — 85

News Digest — 140

Coming Meetings — 181

The Bookshelf — 196

Occupancy Chart — 200

Classified Advertising — 203

What's New for Hospitals — 231

Index to Volume 80 — 257

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AMONG THE AUTHORS



Rhea C. Ackerman

Rhea C. Ackerman, who writes on volunteer service (*p.* 86), is convinced that hospitals have not made the best use of their volunteer workers. "Too often," she says, "they are 'caged off,' labeled volunteers instead of co-workers." Miss Ackerman recently resigned her position of assistant superintendent at Morton Hospital, Taunton, Mass., to return to Los Angeles, where, prior to accepting the post in Taunton, she had been assistant superintendent of Children's Hospital. For several years she has been active in the child safety campaign, and is the author of "Safety—Your Child's Heritage."



Margaret Hill

Margaret Hill knows her hospitals from the outside (Blue Cross) in, and the inside out—as a recent patient. It was her experience as a patient that inspired the article on page 62, in which she directs a few well chosen barbs at the ability of nurses to forget patients' requests, and recommends a simple solution: "Write them down." Miss Hill is manager of the Inter-Plan Bank and Transfer Division of the Blue Cross Commission. Prior to joining the commission staff in 1949, she was manager of the hospital service department of the Blue Cross Plan for Hospital Care, Chicago, for 10 years.



Ann J. Dennison

Ann J. Dennison's article on page 79 also deals with a nursing problem, specifically, the value of a pavilion manager in relieving the head nurse of routine clerical duties. Miss Dennison, who is in process of acquiring her master's degree in sociology from Yale University, served as assistant pavilion manager on a surgical ward of the New York Hospital, New York City, from March 1950 to September 1951. She then joined the staff of the Russell Sage Foundation as research assistant, working on a project in family health care at New York Hospital.



William A. Kozma

William A. Kozma is administrator of Long Beach Memorial Hospital, Long Beach, L.I. A graduate of Rutgers University, 1941, he served in the army from 1941 to 1945 as medical administrative officer. Following his discharge from the army, he was a salesman for a pharmaceutical firm before entering the Columbia University course in hospital administration. He wrote the article on clinical photography which appears on page 81 while he was assistant administrator of Southside Hospital, Bay Shore, N.Y.



Jane S. Pirkey

Jane Sedgwick Pirkey is a food administrator for the California Youth Authority, Sacramento, a position she has held for the last eight years. Mrs. Pirkey's undergraduate academic work was taken at the department of home economics, College of Agriculture, University of Minnesota. Her graduate work was taken at the University of Chicago. The article on allocating food storage space, which appears on page 116, resulted from a series of planning conferences with architectural designers who were planning state-built kitchens.

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Reader Opinion

That Purchasing Agent

Sirs:

I have just finished reading the article in the February issue of The MODERN HOSPITAL entitled "The Circuit Riding Purchasing Agent."

I imagine it was the author's purpose to have this article printed so that he could earn further credits toward his A.C.H.A. fellowship, but if he actually *meant* what he wrote—I would like this small opportunity of answering him.

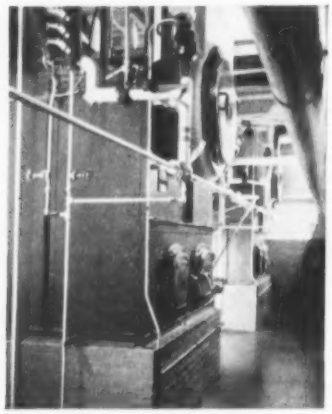
As I understood his theme he is recommending a combined purchasing agent and advisory engineer for a group or groups of 100 bed hospitals who will be paid a stipulated salary by these hospitals in return for which he will buy most of their needed supplies AT COST and provide what technical assistance he is capable of supplying

In the first place, doesn't your author know that 90 per cent of the manufacturers *will not sell* their merchandise direct to any hospital—and it is my opinion that it is their prerogative to sell their product in any way they see fit. If they wish to market their products through local and national dealers rather than set up their own intricate sales force, I believe that is for them alone to decide—and as I have stated, more than 90 per cent have decided to do it in just this way.

In the second place, doesn't your author know that in places where such authorities (bureaus, councils, etc.) have been established the element of human weakness still exists? A large number of the purchasing agents in territories serviced by such nonprofit (????) groups still buy through dealers because they get better service, more companionship, or—let's face it—kickbacks.

Your author is recommending a Utopian socialism that I don't think hospitals want or are entitled to. Why should hospitals as a group be able to buy their essential supplies directly from manufacturers who don't want to sell to them in this manner? Why, if they ever should eliminate the so-called "middle man" and buy direct at cost, shouldn't they—by the same logic—be forced to sell at cost? Most hospital people, as such, are loudly against the complete socialism that has encompassed medicine in other lands—but they do want the few apparent and fictitious privileges that this large-scale planning seems to offer.

It is my limited experience that purchasing in any size hospital would be no problem at all if those in high places would concern themselves with learning a little about the products they have to be "bothered" with and appointing responsible, decently paid people to investigate the best markets and make these purchases. I certainly agree that the administrator in a hundred bed hospital has more to do than be annoyed by salesmen, but I also believe that the central supply nurse or the pharmacist or the nurse in charge of admissions could learn purchasing without too much wasted



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Thank you again for your support and insistence on quality of product.

Sincerely,

J. T. Gibbons

J. Thomas Gibbons
Vice President and
General Sales Manager



effort or time. My first and most confirmed belief is that any honest self-respecting person who is paid a living wage would more than save this wage in his purchases every year if he were not told from whom to buy by someone a little higher in authority than himself.

I am not aiming at a fellowship in the highly esteemed A.C.H.A.—but I do have selfish reasons for writing this letter.

I believe firmly in the American way of doing business—and by that I mean anyone who makes a product to be sold should be able to sell this product in any way he wishes and for any amount of money that he wants to try to get. I believe that if a hospital wants to buy a piece of equipment and the manufacturer has chosen to vend through recognized dealers that this hospital should honor this choice and buy as well as it can, and not continually blame its financial failings on the "high cost of matériel."

The sooner hospitals recognize the fact that the healthiest atmosphere for all to work in is one of "competitive business-like dealing from both sides of the purchasing desk"—the better off we will all be.

We have to recognize the failings in people and acknowledge the ever-present kickback—gift—entertainment—but certainly any person who buys an average of $150,000 worth of expendables a year should be paid enough money and given the esteem worthy of this responsibility. I will also agree that some people placed in these responsible positions are not deserving of *any* respect, but they should be eliminated at the first opportunity, and their purchasing technics should be brought out into the open for all interested people to see and judge (I would like to sit on many of these "juries").

Let's not be blaming the poor maltreated "middle man" for *your* purchasing problems, Mr. Author. Let's clean house in your and every other hospital—if necessary—you as an administrator could do your purchasing on Saturday mornings—or "every other Tuesday"—and, granting that you are completely honest, I'm sure you'd find that most "middle men" would be just as helpful as they could be.

"KICKBACK" IS THE CULPRIT

I think you put your finger on the real answer when you mentioned the predominant technic of "kickback." No middle man can sell at a competitive, reasonable markup of 9 per cent to 14 per cent if he has to cater to the O.R. superintendent, the C.S.R. supervisor, the housekeeper, the purchasing agent, the administrator, ad infinitum. Somebody has to pay for all of this proselyting, and so long as it is tolerated and made one of the necessary rules of "doing business" all hospitals are going to pay more than they should for their matériel.

In closing let me say that with the low point that the American morals have reached, and with the limited finances of hospitals, a completely honest purchasing agent who has no interest at heart except the hospital he works for is going to be hard to find, but I think looking for him would be much more satisfactory than tearing down the accepted and proven way of merchandising that has helped America grow.

If you ever find him, please let me know and I will take him away from you with an offer of more money for his services.

William A. Ehret

Salem, Ohio





Above, operator easily slides load from stainless steel Troy "Slyde-Out" washer.

Atchison, Topeka and Santa Fe Hospital Chooses *"Slyde-Out"* Washers



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This is the story of Humpty Dumpty and his friends who came to cheer up all the children who have to be patients for a time in the Williamsport Hospital, Williamsport, Pa.:

"The assistant director of nurses decided that the children's department needed livening up. Located in a wing we'd just finished erecting, the department was very sunny and pleasant (much more so than the building we'd moved from, which had ceilings 14 feet high and very drab, dark walls). But still it needed something to give it some pep—and to give the youngsters a little pleasure when they had to be there.

"So she and the public relations director put their heads together and decided that some of my Mother Goose chums and I would be a great addition to the children's department (a wise decision, I'm sure!) and they thought they'd ask the children in the schools to fashion us, since children know us so much better than grownups do!

"Then Miss Keller, who is the supervisor of art education in Williamsport schools, called together the art teachers in the junior and senior high schools, and told them how she thought we'd help the little patients to feel at home when they came to the hospital. We could give them a boost when they were admitted, and were frightened by strange surroundings and unfamiliar faces.

"All the teachers liked the idea, too, and when they told the boys and girls who were to make us, they really got excited! You can see from the picture how they gave us our start in life. (That's me on the left.)



Humpty Dumpty sits on the wall of a ward in Williamsport Hospital, at Williamsport, Pa.

"That's the story of how we came into being. To get down to specifications, we're all about 30 inches tall; we have a wall-board skeleton, and our makeup and clothes are strictly hand tailored (in oil paints).

"When we were all finished, there were 16 of us. We had decided to include among our Mother Goose crowd a few from the Walt Disney set, and

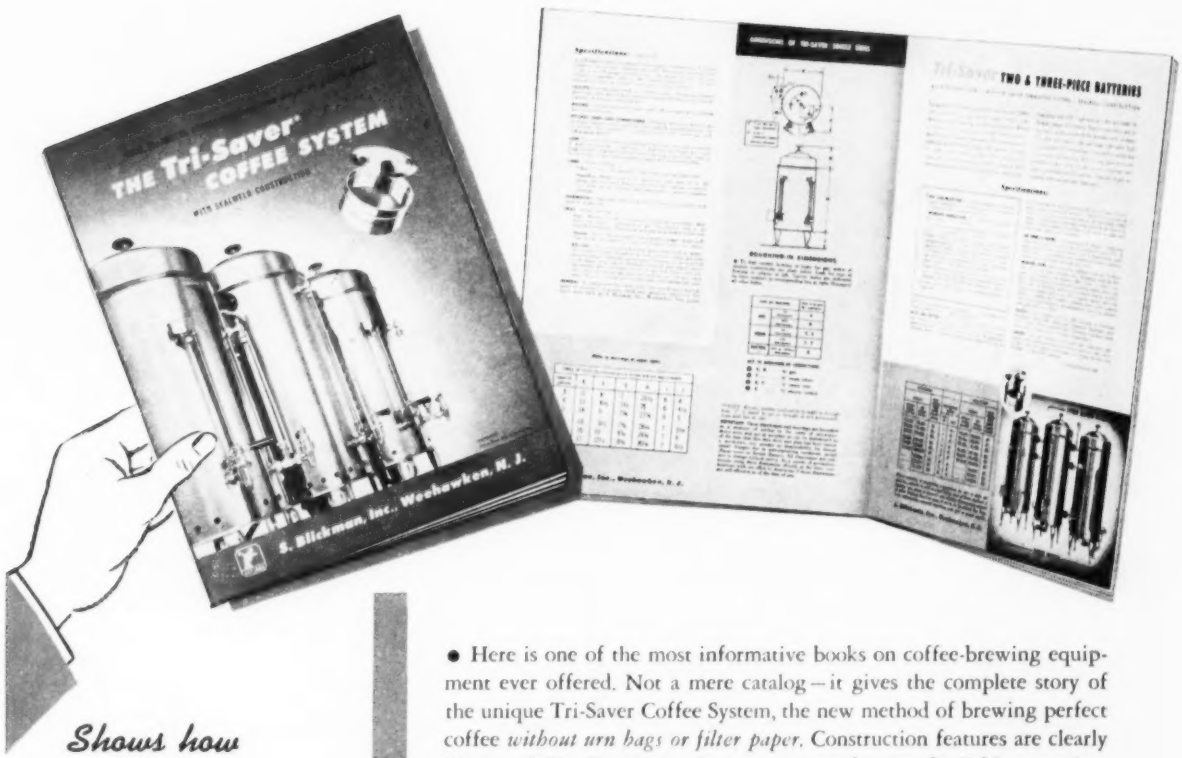


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valuable illustrated book gives you all the facts, specifications, dimensions



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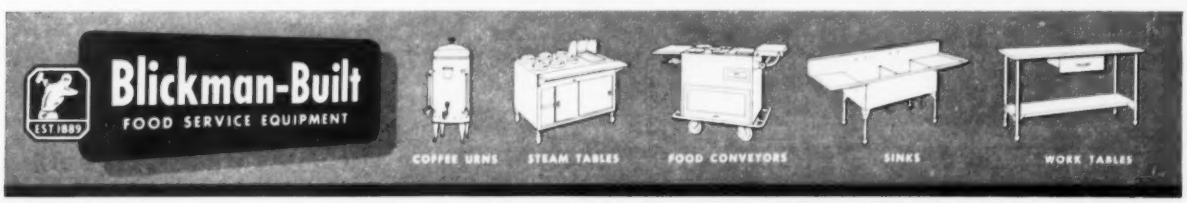
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• Here is one of the most informative books on coffee-brewing equipment ever offered. Not a mere catalog—it gives the complete story of the unique Tri-Saver Coffee System, the new method of brewing perfect coffee *without urn bags or filter paper.* Construction features are clearly illustrated. You'll see how they assure you of years of reliable operation. All types of urns are shown. The book contains detailed specifications, dimensions and other information that will help you select the urn that best fits your requirements.

If you're interested in long service life, trouble-free coffee-making and a consistently delicious brew — "Tri-Saver" is the best investment you can make. Send for this valuable handbook now. Copies are limited. Kindly write on your letterhead.

LOOK FOR THE TRI-SAVER NAME-PLATE—YOUR PROTECTION AGAINST INFERIOR SUBSTITUTES

S. Blickman, Inc., 1506 Gregory Ave., Weehawken, N. J.



I must say we all get along quite well. Not that we have too much time for social activities, of course. We're far too busy in the rooms and corridors keeping the youngsters happy.

"We've had a number of visitors since we've been here. Of course, only their parents may come in to see the children as a rule, but we were brand new when the hospital held open house, and we certainly entertained many, many people that day.

"Then, one day, Miss Keller brought the student teachers in to see us. They are the ones still in college, who will someday teach art in the public schools. They liked us too and agreed that the creation of such figures for hospitalized children was a mighty good investment in community service for schools to make.

"I don't want to sound conceited, but we all think we do a pretty good job of making the little ones feel at home here. At least, their parents and their doctors have told us so, and that's enough for us."—MARION E. MAYNARD, *director of public relations and personnel, Williamsport Hospital, Williamsport, Pa.*

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The Coffee Headache

There are two paradoxes encountered in managing a hospital. One is that "little things" frequently cause more confusion and discontent than "big" ones, and the other is that sometimes our most difficult problems arise as a result of our trying to do something for people.

We have found that both of these paradoxes apply to serving free coffee to certain selected and favored groups of employes, a practice which we started a year ago in a small way as a means of disposing of the leftover coffee in the ward kitchens which otherwise would have been thrown down the drain.

The extent to which this small gesture of good will has grown is almost incredible. Here are the facts as of today: 3450 cups of free coffee are now being served in the floor kitchens each week. The paper cups and spoons alone cost the hospital $59.21 a week. The cream and sugar cost $11.15. The coffee costs $22.50. Total direct expenses are $92.86 a week, or $4,828.72 per year. The price of coffee is still increasing.

CANNOT BE JUSTIFIED

How can this be justified? The answer is that it can't. At a time when the hospital is $1,500,000 in debt, with an extensive alteration program still in progress—at a time when all members of the staff are being urged to contribute to the institution to help meet this deficit—at a time when the hospital is taking on additional heavy obligations with respect to the clinical departments in the medical college—at a time when rates to patients have been raised to try to balance the budget, such a practice, even if admittedly a benefit to the favored recipients, cannot be condoned.

It is not easy, nor is it ordinarily desirable, to take away from employes a privilege to which they have become accustomed and to which they feel themselves entitled. The practice of serving free coffee, however, has quite obviously mushroomed to such an extent that it is now completely out of control, and it would be unfair to continue it.

We are meeting with supervisory groups at the present time to discuss this problem to see if some satisfactory alternative can be worked out.—THOMAS HALE JR., *administrator, Albany Hospital, Albany, N.Y.*

in hospitals...JOHNSON CONTROL



St. Michael's Hospital, Grand Forks, N. D. Maguolo & Quick, architects, St. Louis, Mo.; J. McClure Kelly & Co., heating contractors, Minneapolis, Minn.



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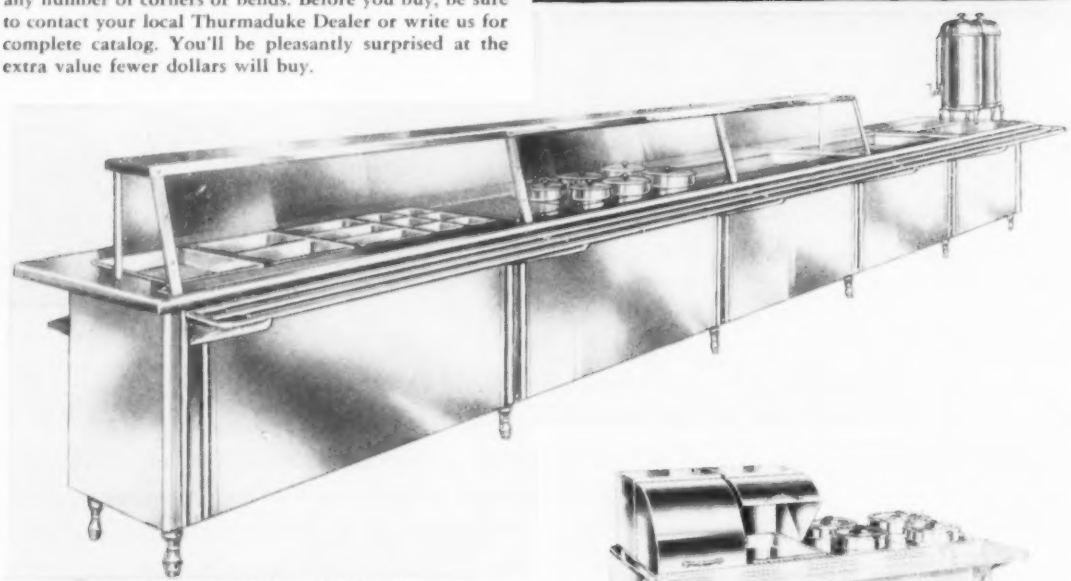
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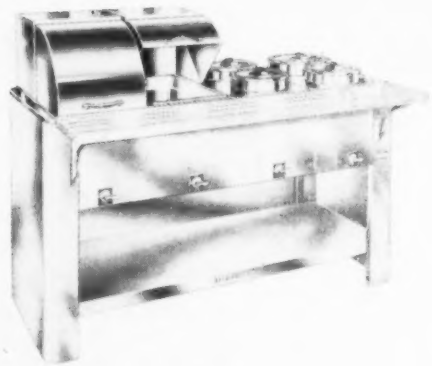
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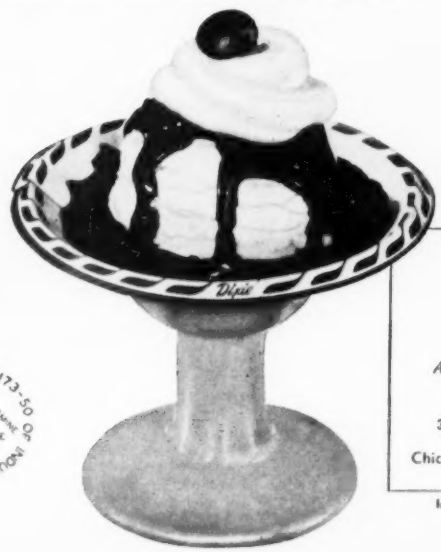
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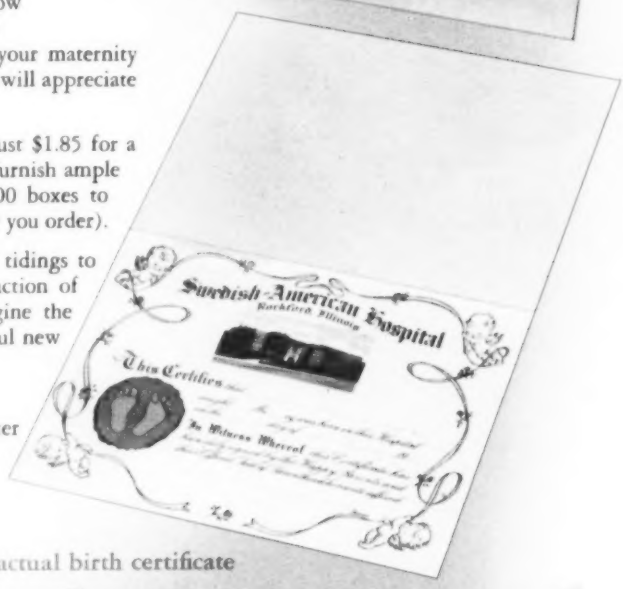
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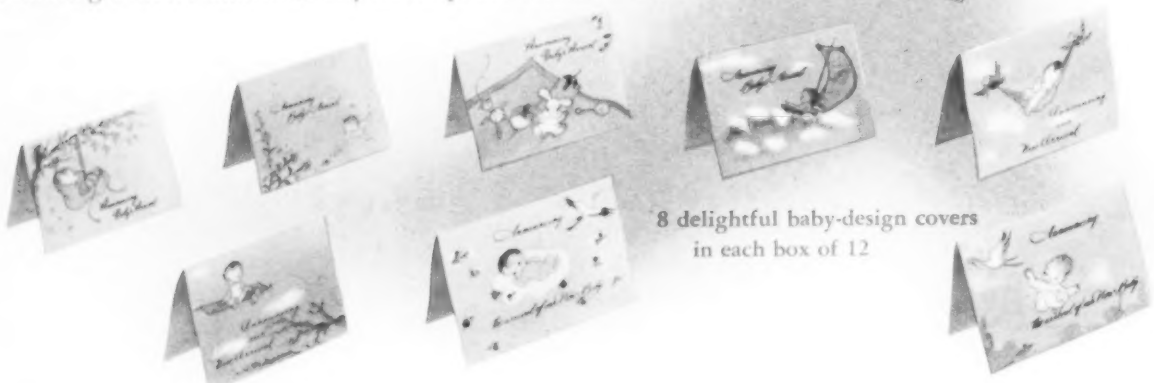
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INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—30th Edition

Abbott Laboratories 101
Airtemp Division, Chrysler Corp. 223
Alconox, Inc. 176
Aloe Company, A. S. (HPF) 139
Alvey-Ferguson Company 172
American Appraisal Company 250
American City Bureau 194
American Cyanamid Company 15
American Cystoscope Makers, Inc. 191
American Hospital Supply Corp. (HPF) ..... following page 32
American Institute of Laundering 135
American Laundry Machinery Co. (HPF) 29
American Machine & Metals, Inc. (HPF) 9
American-Marietta Company 144
American Radiator & Standard Sanitary Corp. 149
Anchor Brush Company 217
Angelica Uniform Company 129
Architectural Record 248
Arco Company 182
Armour Laboratories 25
Armstrong Company, Inc., Gordon (HPF) ..... following page 48
Aseptic-Thermo Indicator Company 210
Auth Electric Company, Inc. (HPF) 233

Baker Linen Company, H. W. 197
Baker-Roos, Inc. 148
Bard, Inc., C. R. 196
Bard-Parker Company, Inc. (HPF) 102
Barnstead Still & Sterilizer Co. (HPF) ..... following page 32
Bassick Company (HPF) 207
Bauer & Black (HPF) 36, 177
Baxter Laboratories 5
Bishop & Company Platinum Works, J. 189
Blickman, Inc., S. (HPF) 11, 119, 141
Bloomfield Industries 217
Bolta Company 31
Brillo Mfg. Company 218

Cambridge Tile Mfg. Company 20, 21
Canada Dry Ginger Ale, Inc. 48
Carbisulphoil Company 250
Carrier Corporation 160
Cash, Inc., J & J (HPF) 254
Castle Company, Wilmot (HPF) 1
Chamberlin Company of America (HPF) 28
Chatham Mfg. Company (HPF) 135
Classified Advertising 203, 226
Coca-Cola Company 204
Colgate-Palmolive-Peet, Inc. 179
Collins, Inc., Warren E. (HPF) 254
Commercial Solvents Corp. 35
Congoleum-Nairn Inc. (HPF) 241
Continental Coffee Company 136
Continental Hospital Service, Inc. (HPF) 113
Cramore Fruit Products, Inc. 214
Crane Company (HPF) 125
Cumerford Inc. 98
Cutter Laboratories 87

Dant & Russell Company (HPF) 213
Darnell Corporation, Ltd. (HPF) 170
Davis & Geck, Inc. (HPF) 99
Day-Brite Lighting, Inc. 227
Debs Hospital Supplies, Inc. 32
Deknatel & Sons, Inc., J. A. 220
De Puy Mfg. Company, Inc. (HPF) 211
Detroit-Michigan Stove Company 45
Dewey & Almy Chemical Company 186
Dexter & Staff, Fred 210
Diack Controls (HPF) 92
Diana Mfg. Company 163
Diebold Inc. 235
Dixie Cup Company 195
Don & Company, Edward 214
Duke Mfg. Company (HPF) 14
Dundee Mills, Inc. 249
Dunham Company, C. A. 44

Eastern Venetian Blind Company 198
Eastman Kodak Company 89
Economics Laboratory, Inc. 131
Edison Chemical Company (HPF) 162
Edison, Inc., Thomas A. 187
Edwards Company, Inc. 180, 181
Eichenlaubs 240
Emerson Electric Mfg. Company 178
Ethicon Suture Laboratories Inc. (HPF) 96

Fabrikators, Inc. (HPF) 34
Fairbanks, Morse & Company 236
Fenestra Building Products 153
Finnell System, Inc. 123
Flex-Straw Corp. (HPF) 110
Florida Citrus Commission 17
Foster Brothers Mfg. Company (HPF) 190
Frick Company 224
Frigidaire Division ..... facing page 17

Geerpres Wringer, Inc. 240
Gennett & Sons, Inc. 226
Glasco Products Company 40
Globe Automatic Sprinkler Co., Inc. 8
Guth Company, Edwin F. 146

Hall China Company ..... 3rd Cover
Haney & Associates, Charles A. (HPF) 218
Hard Mfg. Company (HPF) 205
Heinz Company, H. J. 151
Herrick Refrigerator Company (HPF) 207
Hild Floor Machine Company (HPF) 192
Hill-Rom Company, Inc. (HPF) 152
Hobart Mfg. Company 117
Hollister Company, Franklin C. ..... following page 16
Horlicks Corporation 230
Horner Woolen Mills Company 238
Hospital Purchasing File 154, 155
Hotpoint Company (HPF) ..... 2nd Cover

Huntington Chair Company....206
Huntington Laboratories, Inc. (HPF)....199

Institutional Products Corp....37
International Minerals & Chemical Corp....30
International Nickel Company, Inc....237

Johns-Manville....183
Johnson & Johnson....27
Johnson Service Company....13
Judd Company, H. L. (HPF)....184

Kalistron, Inc....127
Kenwood Mills (HPF)....244
Kewanee-Ross Corporation....6
Keyes Fibre Sales Corporation (HPF)....150
Kraft Foods Company....147

Landers, Frary & Clark....159
Lehn & Fink Products Corporation (HPF)....138, 221
Leonard Valve Company (HPF)....222
Lilly & Company, Eli....3
Linde Air Products Co.,
A Div. of Union Carbide & Carbon Corp (HPF)....97
Ludman Corporation....175

McKesson Appliance Company....111
Macalaster Bicknell Parenteral Corp. (HPF)....216
Master Metal Products, Inc....200
Meierjohan-Wengler....236
Merck & Company, Inc....24
Metalab Equipment Corp....192
Milwaukee Lace Paper Company....206
Minneapolis-Honeywell Regulator Co. (HPF)....42
Multi-Clean Products, Inc....165

National Biscuit Company....143
National Cash Register Company (HPF)....247
National Welding Equipment Co....208
Nelson Company, Inc., A. R. (HPF)....12
Nestle Company, Inc....212
Niagara Manufacturing & Distributing Company....41

Oakite Products, Inc....10
Ohio Chemical & Surgical Equipment Company (HPF)....43
Olson Mfg. Company, Inc., Samuel (HPF)....238
Onondaga Pottery Company....185
Orchard Paper Company....158
Orthopedic Frame Company (HPF)....168

Parke, Davis & Company....91
Paterson Parchment Paper Company....188
Pequot Mills....246
Permutit Company....156
Pfizer & Company, Inc., Charles....109
Philco Corporation....219
Pick Company, Inc., Albert....150
Pioneer Rubber Company (HPF)....46
Pittsburgh Plate Glass Company....following page 16
Plastic Tag & Trade Check Company....252
Plymouth Rubber Co., Inc. (HPF)....169
Polar Ware Company (HPF)....173
Potter Mfg. Corporation....222
Powers Regulator Company....18, 19
Procter & Gamble....202
Prometheus Electric Corporation (HPF)....137

Quicap Company, Inc....242

Ready-Power Company....225
Republic Steel Corporation....253
Riker Laboratories, Inc....251
Ritter Company, Inc. (HPF)....107
Ross, Inc., Will....105
Royal Metal Mfg. Company (HPF)....145
Russell Company, F. C....171

St. Marys Woolen Mfg. Company....252
Salvajor Company....213
Sealright Company....215
Seamless Rubber Company (HPF)....7
Seven Up Company....161
Sexton & Company, John....115
Shampaine Company (HPF)....245
Simmons Company (HPF)....39, 209
Simtex Mills....133
Sloan Valve Company....4th Cover
Smith & Underwood (HPF)....92
Spencer Turbine Company....211
Sperti-Faraday, Inc....166
Squibb & Sons, E. R....93
Standard Brands Inc....167
Stromberg Time Corporation (HPF)....239
Swartzbaugh Mfg. Company (HPF)....38

Thonet Industries, Inc....16
Tile-Tex Division....255
Titusville Iron Works Company,
Div. of Struthers Wells Corp. (HPF)....164
Toastmaster Products Div. of
McGraw Electric Company (HPF)....121
Torrington Company....221
Troy Laundry Machinery Division (HPF)....9

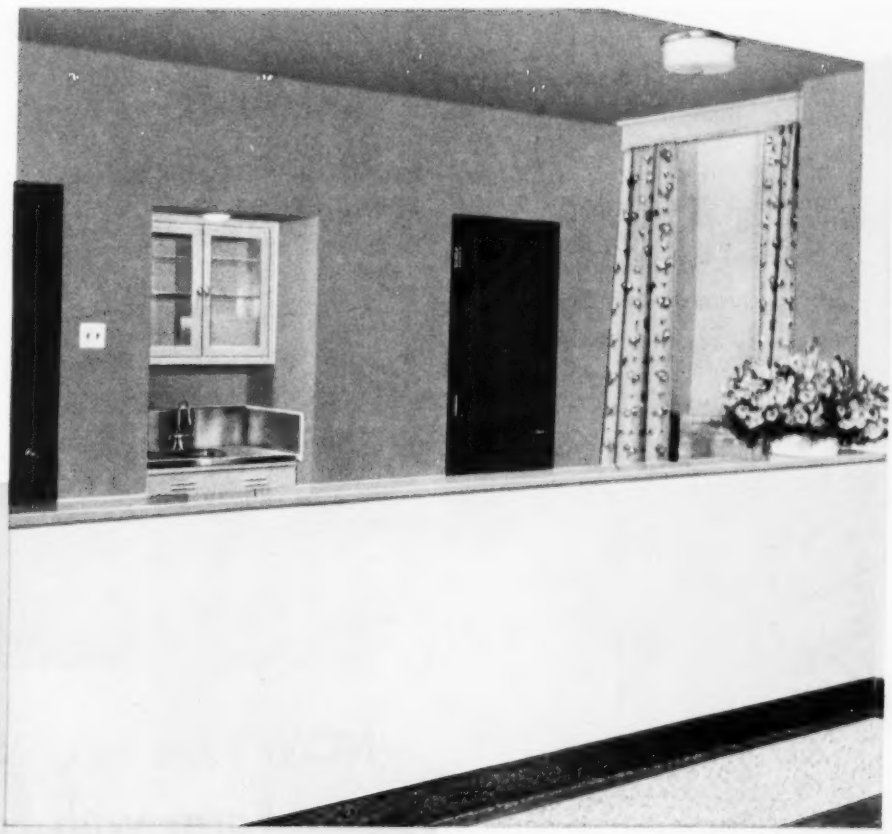
Union Carbide & Carbon Corp.,
Linde Air Products Co. (HPF)....97
United States Bronze Sign Co., Inc. (HPF)....246
U. S. Hoffman Machinery Corp. (HPF)....193
U. S. Industrial Chemicals Co. (HPF)....103
Universal Dishwashing Machinery Co. (HPF)....142
Upjohn Company....229
Utica & Mohawk Cotton Mills, Inc....243
Uvalde Rock Asphalt Company (HPF)....following page 48

Visi-Shelf File, Inc....242

Wander Company....95
Webb Mfg. Company....244
Weck & Company, Inc., Edward....104
West Disinfecting Company....23
Westinghouse Electric Corporation....26
White Mop Wringer Company....244
Wilmot Castle Company (HPF)....1
Winthrop-Stearns, Inc....33
Wiremold Company....148
Witt Cornice Company....225
Woodard Sons, Lee L....157
Wright Mfg. Company....174

Yale & Towne Mfg. Company (HPF)....22
York Corporation....201

Zimmer Mfg. Company....112



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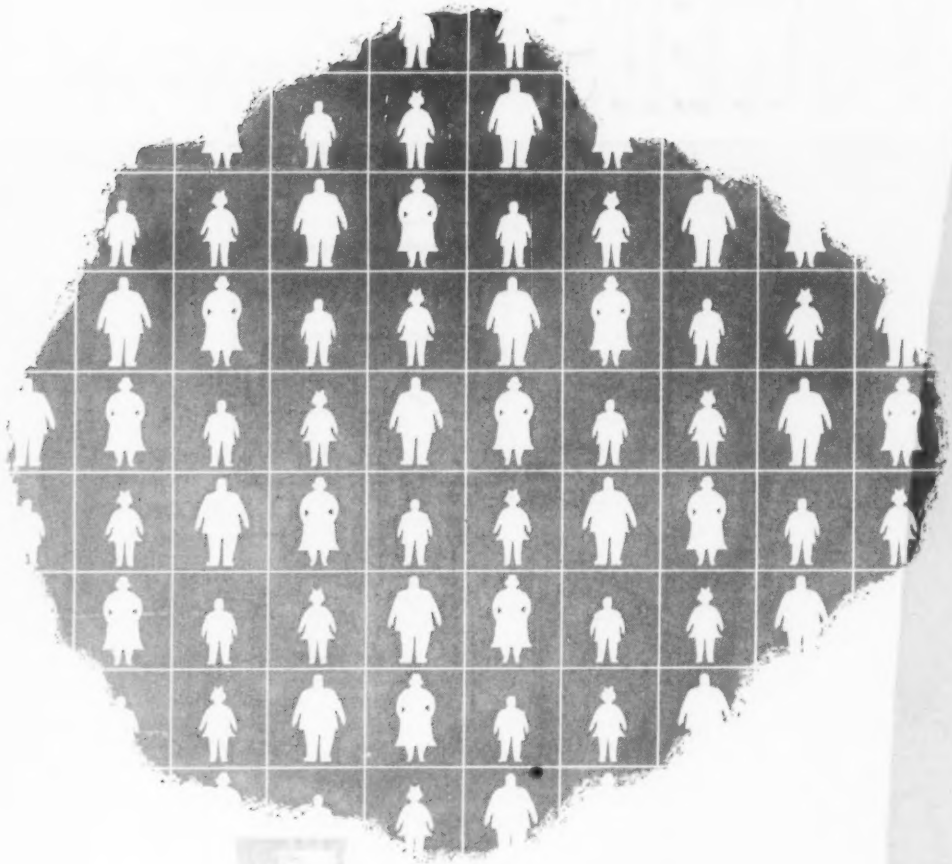


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A 4-oz. glass of orange or grapefruit juice half an hour before lunch and dinner can materially reduce the demand for high-caloric foods, and enable the obese to adhere to their dietary regimens more satisfactorily. Citrus is particularly appealing because it is a "natural", non-medicinal, appetite-appeaser.

Other advantages of citrus, as an anoretic agent, are its readily utilizable carbohydrates (approximately 10-15 gm. per glass) which combat hypoglycemia—its almost universal availability—its popular flavor—and its economy.

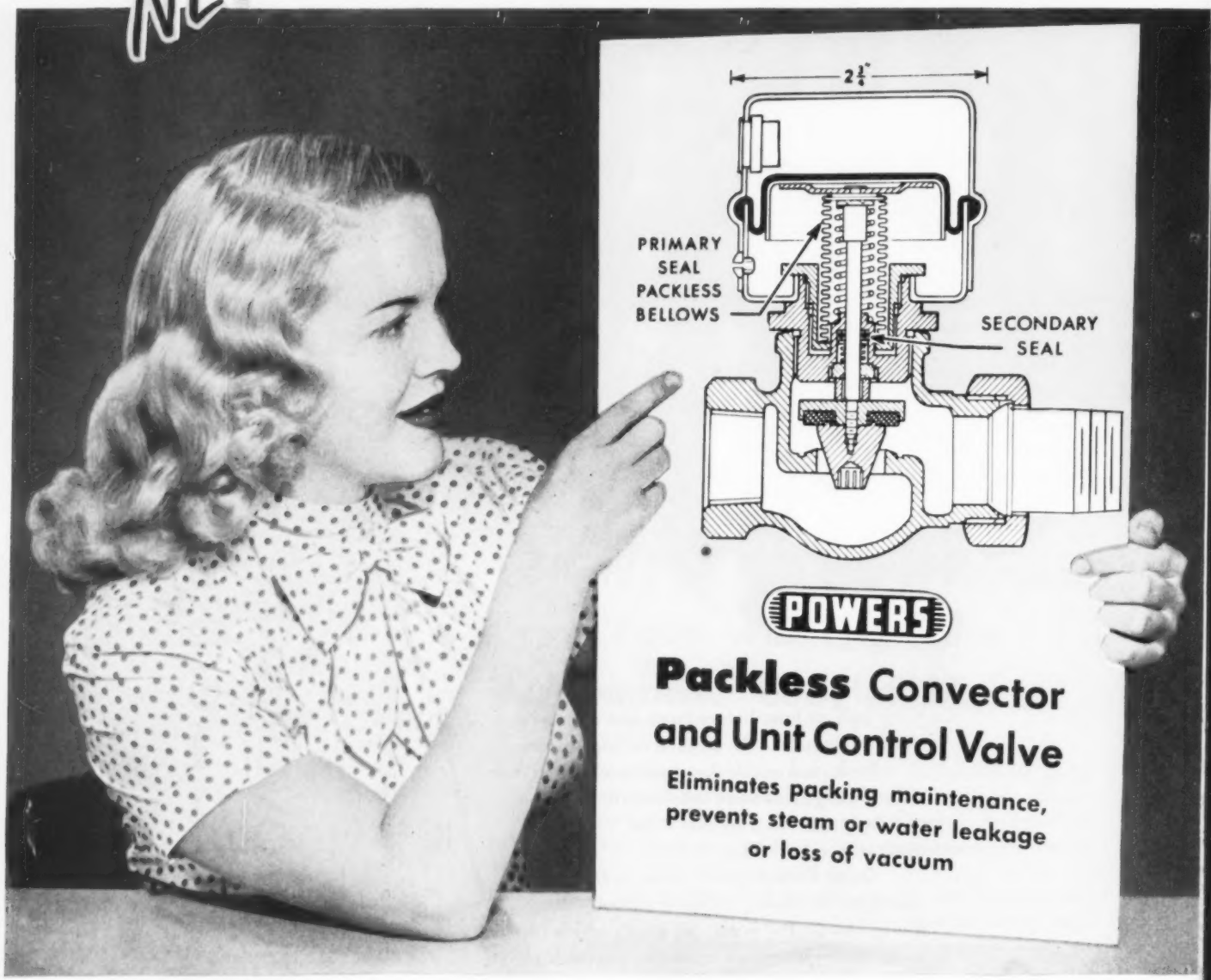
FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

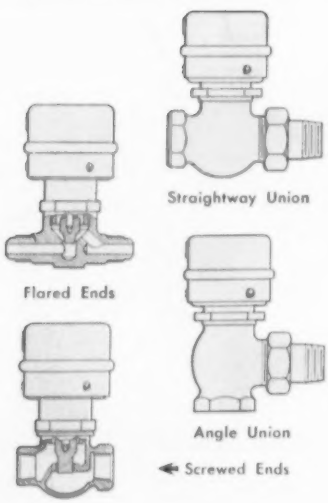
FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES



NEW! POWERS PNEUMATIC *Systems of*

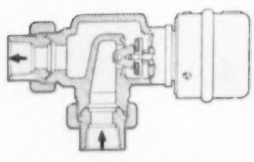




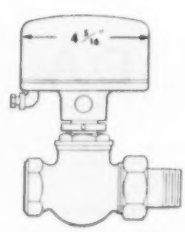
POWERS-**PACKLESS**-VALVES

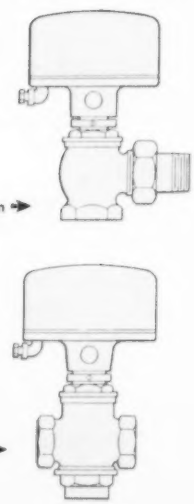
Never require re-packing.

Real Economy in Maintenance year after year



Available in various types and sizes for control of convectors, unit ventilators, unit air conditioners and radiators.





Automatic Temperature Control
Now Include

POWERS-**PACKLESS**-VALVES

For Controlling Convectors, Unit Ventilators, Unit Air Conditioners and Radiators.

Now, at NO Extra Cost — users of Powers pneumatic control systems will get the additional benefits of still lower operating and maintenance costs — insured by Powers packless valves.

Duo-seal Construction Gives Them Superior Performance. Bronze packless bellows is the Primary Seal which eliminates packing maintenance — packing friction — steam and water leakage or loss of vacuum. Secondary Seal permits servicing of valve top without draining the water system or shutting off the steam supply.

Typical Specifications for POWERS-Packless-Pneumatic Control Valves

Control valves for convectors, radiators and unit ventilators shall be packless type with bronze packless bellows to eliminate steam and water leakage or loss of vacuum. This packless bellows shall be located so that it is not subject to corrosive action of the steam or water. A spring-loaded secondary seal shall be provided to permit convenient inspection or servicing of valve top without draining the water system or shutting down the steam supply.

Valve sizes shall be determined by control manufacturer for capacities specified. Type of valve body and valve top to be used shall be as required to best satisfy the application.

Valves shall be equipped with phosphor bronze bellows or Neoprene diaphragms of sufficient size to close off against specified line pressures. Diaphragms shall be replaceable. Valves shall be equipped with characterized throttling plugs to insure a measured flow of steam or water in direct relationship to the demand of the controlling thermostat.

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OVER 60 YEARS OF AUTOMATIC TEMPERATURE CONTROL



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No Loss of Vacuum

... leakage of air reduces efficiency of heating system and increases corrosion in return lines



No Steam or Water Leakage

(b18)

Only a Few of **POWERS** Complete Line of Modern Control Valves for Regulating Heating and Air Conditioning Systems



In the main kitchen, Citrus Yellow Suntile combines sparkling cleanliness and high light reflection for better vision in interior areas.



You can make the building part of the cure with FUNCTIONAL COLOR *Suntile*

The handsome new Jackson Memorial Hospital in Miami, Florida, shows how a single versatile material—real clay Suntile—serves as a multi-purpose finish in any hospital area.

"We have been very happy with the results," says Dr. C. C. Hillman, Executive Director.



Wainscoting of Light Jade Green Suntile brightens this clean-up room, also promotes sanitation.



Jackson Memorial Hospital, Miami, Fla., Steward & Skinner, Architects.



In operating rooms, Sea Green Suntile provides a neutralized color which reduces eye fatigue, and helps surgeons' vision by supplying a restful complement to colors of tissue.

In scrub-up rooms, kitchens and operating rooms, Suntile is used as an important aid to sanitation. Its glazed, impervious surface set in tight, thin mortar joints discourages bacterial growth, permits thorough cleaning with minimum time and effort.

Architects Steward & Skinner also make skillful use of Suntile's functional colors—which are scientifically planned to fit hospital needs by Faber Birren, nationally known color authority.

In patient areas, light, cheerful Suntile colors can have a tonic effect. Where exacting visual tasks are performed, more neutral shades help vision and reduce fatigue.

And wherever it is used, Suntile provides the other lifetime benefits of quality clay tile —permanence, freedom from refinishing, fire-safety, substantial maintenance savings.

To learn how Suntile can help your hospital serve patients and staff better, write for free copy of our booklet, "Suntile Color Recommendations." Address Dept. MH-6.



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YALE*

Sounds a new note for greater harmony with modern design



ALUMINUM HARDWARE



Modern as the hardware itself, this folder is a valuable addition to your files. Write for it today.

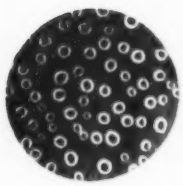
Here's lasting beauty in modern design. YALE aluminum hardware gives new beauty and efficiency ...new durability and maintenance ease, too. Lighter anodized aluminum is famous for strength as well as ability to resist scratching, marking and tarnish. And, the soft lustre of the satin finish enhances every modern decor. Of course, the famous YALE quality is built-in ...to give every advantage you want and need. Wire for details! Yale & Towne Manufacturing Company, Builders Hardware Division, Stamford, Connecticut.

THE YALE & TOWNE MFG. CO., STAMFORD, CONN.
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Fog 1,000 cu. ft. in 3 seconds for 5¢



Top — Magnified photo of uniform 8 micron droplets produced by precision-machined suction nozzles of West Atomizing equipment. "Dry mist" remains air-borne for prolonged periods.



Bottom — Magnified photo of droplets produced by ordinary hydraulic compressor sprayers. Vary from 2 to 300 microns. Larger droplets fall, wetting floors and reducing effectiveness.

— and with only 1 ounce of Vaposector — for complete control of flying insects. Double this dosage for crawling insects.

Impossible? Not with a permanently installed West Atomizer. 10 suction nozzles atomize a "dry mist" of extra-potent insecticide. Droplets are so small they hang in the air . . . seep into every crack . . . penetrate delicate insect breathing tubes.

It's an unbeatable combination. High potency Vaposector — sprayed with super-efficient West atomizing equipment. One man does the job. There's only one valve to open. You can fog your entire plant simultaneously.

West has a complete line of insecticides and atomizing equipment ranging from permanent installations to portables. A West specialist will be glad to make a survey and set up an Insect Control Program to fit your needs. Without obligation. Just mail the coupon.

YES! Tell us about your Insect Control Plan

☐ Please send me the West Insect Control Booklet

☐ Have a West Insect Control Specialist call DEPT. 12

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Rehabilitating severely crippled arthritics with physical therapy and

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The concurrent use of CORTONE and physiotherapy makes it possible to increase range of motion and muscle power, to relieve pain, and thus to rehabilitate severely handicapped patients.

Snow, W. B., and Coss, J. A., N. Y. State J. Med. *52: 319, Feb. 1, 1952*

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

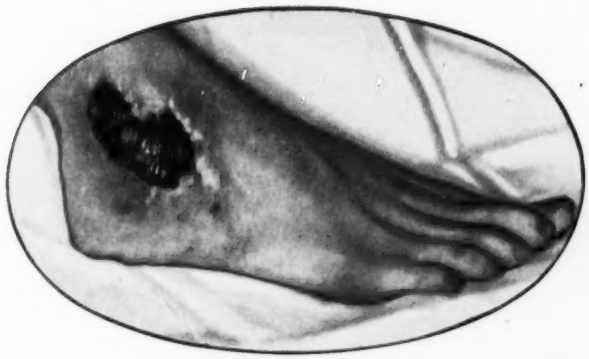
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Manufacturing Chemists

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Chronic Inflammatory Hypertensive Ulcer of 7 months duration, resistant to various ointments, autogenous blood, 5 weeks of hospitalization for treatment, and lumbar sympathetic block.



to effect physiologic debridement

Use of 8 vials of Tryptar in powder form and in solution permitted successful skin grafting 3 days after institution of therapy.



within hours

Tryptar® dissolves necrotic tissue, surface coagula, clotted blood, purulent secretions and fibrinous strands by physiologic enzymatic action. Tryptar has no adverse effect on normal tissue or normal healing processes. Neither sensitivity to Tryptar nor antigenicity has been reported.

Tryptar is also effective in the management of crush injuries, burns, soft tissue abscesses, osteomyelitis, fistulae and sinus tracts.

Also available as Tryptar Aerosol for the treatment of respiratory conditions associated with clogging, purulent bronchial secretions.

For detailed information write Medical Consultant Service, The Armour Laboratories, 520 N. Michigan Ave., Chicago 11, Ill.

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PHYSIOLOGIC THERAPEUTICS THROUGH RESEARCH

SIEMENS

RADIOLOGICAL EQUIPMENT NOW AVAILABLE IN U. S. THROUGH WESTINGHOUSE

The Siemens-Reiniger line of specialized radiological equipment which will include body section, convergent beam therapy, Chaoul therapy, and other units is now being distributed nationally by the X-ray Division of Westinghouse Electric Corporation.

The line of specialized equipment made by Siemens-Reiniger-Werke of Germany includes:

- Universal and transversal planigraphs, angiography device and multiple-leaf diaphragm.
- Convergent beam therapy, pendulum therapy, rotational therapy, all giving high depth dose with low skin exposure without multiple port techniques.
- Chaoul therapy unit, for skin contact treatment.

Further details about the Siemens-Reiniger equipment are available — for example:

The convergent beam therapy unit achieves percentage depth doses of 200 to 300% at a tumor depth of from 4 to 10 cm. In operation, the tubehead describes a spiral path on a spherical sector. This results in a conical beam which can be directed so that the tumor lies in the apex of the beam. The maximum dose is, therefore, concentrated on the tumor area; in areas other than the tumor, the dose diminishes rapidly due to divergence of the rays.

The Siemens-Reiniger Universal Planigraph takes body-section radiographs at 56″ target-film distances with the patient in any position: vertical, horizontal, oblique, or up to 90° Trendelenberg. Foreign bodies or cavities are located with speed and precision by fluoroscopy before radiographing; patient dosage, time, and film usage are reduced to as little as 1/10th that in conventional body-section techniques.

These brief examples indicate the scope, precision, and the unique features of the Siemens line of equipment now handled by Westinghouse. For full details, call your Westinghouse X-ray Representative, or write to Department E-87, Westinghouse Electric Corporation, X-ray Division, 2519 Wilkens Avenue, Baltimore 3, Maryland.

(This equipment will be on exhibit at the Seventh International Congress of Radiology in Copenhagen.)

X-RAY DIVISION · WESTINGHOUSE ELECTRIC CORPORATION · BALTIMORE 3, MARYLAND

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PORTABLE UNITS
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YOU CAN BE SURE... IF IT'S

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NUPAK OB PADS

Save up to 26% in cost



12" Nupak Pad replaces two or more shorter pads used in tandem. Cuts costs up to 26% . . . saves nurses' time.

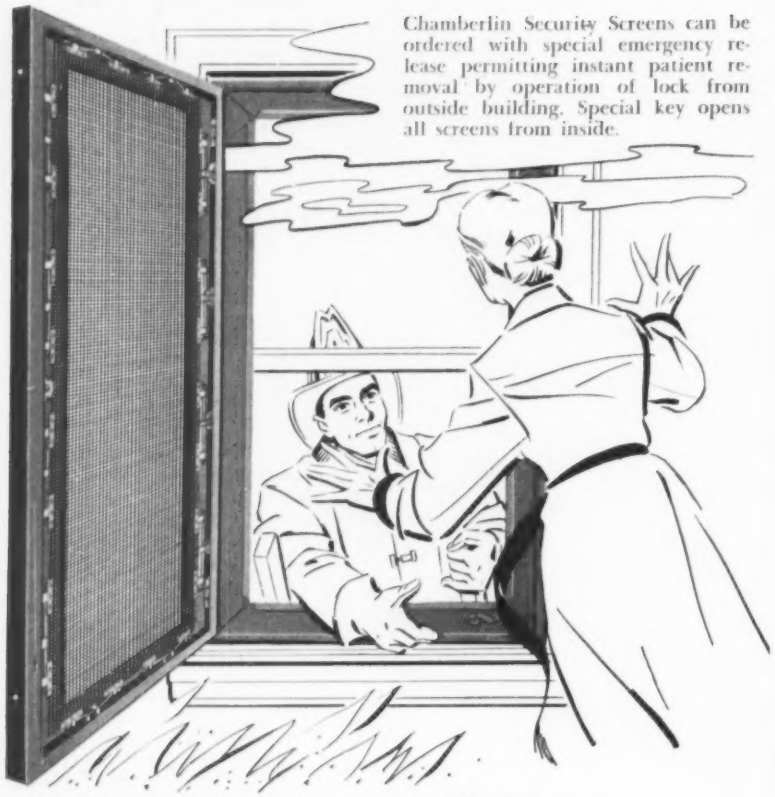
also

Provides extra protection **and patient** comfort.

HOSPITAL DIVISION

Johnson & Johnson

NEW BRUNSWICK, N. J. CHICAGO, ILL.



Chamberlin Security Screens can be ordered with special emergency release permitting instant patient removal by operation of lock from outside building. Special key opens all screens from inside.

Reduce the threat of disaster, too, with Chamberlin Security Screens

You reduce the threat of disaster. No grilles, no bars to trap patients in case of fire. No stubborn or jammed locks to hinder rescue operations. Exclusive Chamberlin locks permit *instant* patient removal from outside in emergencies.

You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

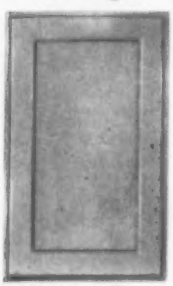
You reduce sash repair and paint costs. Chamberlin Security Screens mounted at recommended distances from window help prevent mutilation of window frames, sash, paint.

You reduce grounds maintenance costs. Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects.

You eliminate insect screen costs. Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands usual abuse. Admits ample light and air.

Over the years, these savings will more than offset your original screen costs. Yet they're only a few of the savings and services other hospital administrators receive every day (see right). Let our Hospital Advisory Service give you full details. Write today.

The right screen at the right cost to fit your patients' needs



Detention Type



Protection Type



Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for non-violent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings: Replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: Prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICH.

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Caulking, All-Metal Combination Windows, and Insect Screens

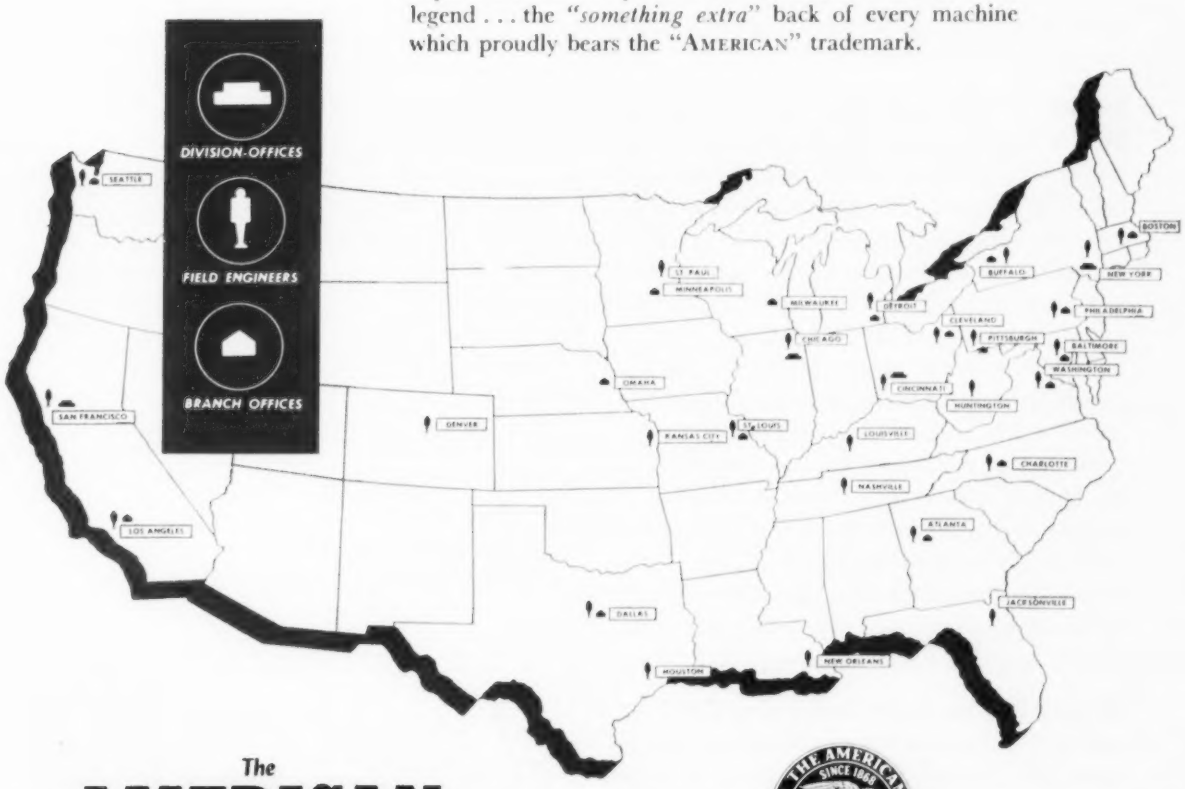
"AMERICAN" COVERS THE NATION
with Convenient, Dependable Service

Ready to serve hospitals and institutions everywhere, AMERICAN field engineers are spotted all over the nation, from coast to coast.

In some cities, as many as ten AMERICAN service engineers stand ready to respond to any call. In the field, other AMERICAN service engineers and technicians are in constant touch with their headquarters for assignment wherever needed.

In strategically located cities, AMERICAN also keeps a stock of repair parts for rush shipment in any emergency.

Among hospitals and institutions everywhere, AMERICAN's nation-wide service and recognized reputation for dependable follow-up on each installation has become a legend . . . the *"something extra"* back of every machine which proudly bears the "AMERICAN" trademark.



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LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

Ac'cent® makes food flavors sing... makes your cash register ring!

Nothing sells food like flavor... and nothing brings out flavor like Ac'cent. Delicious, flavorful food is the *one thing* about a restaurant that builds up a steady, repeat business. And no matter what your type of restaurant operation is, Ac'cent (pure monosodium glutamate) is the *one thing* that ensures flavor. Whether yours is a short order counter where speed and ease of preparation are all-important...a cafeteria where food waits and waits for people...or one of those special restaurants with a chef who prides himself on turning out nothing-but-the-most-enjoyable food—you'll find that Ac'cent makes good food taste better every time!

Ac'cent is the *only* type of seasoning that *intensifies*—and *holds*—natural food flavors. Its function, unlike other preparation aids, is to *bring out* every bit of *natural* flavor... and then *keep* that flavor from kitchen to table. With just two simple taste tests, you can actually prove this to yourself. First of all, sample one of your most popular dishes prepared, without Ac'cent, in the usual way. Then sprinkle Ac'cent in it, and *taste the difference!* You'll find more—*much* more—fresh-from-the-vine flavor in vegetables; more tempting, "chickeny" flavor in chicken; more *natural* flavor in everything. Second, sample a bit of food that has been on a steam table for the usual period of time. Then add Ac'cent and see how wonderfully different it tastes. Suddenly the dish becomes full of bright, sparkling flavor—*natural* flavor!

Ac'cent is a basic seasoning that should be used not just occasionally, but in every kind of meat, fish, poultry, soup, sauce, gravy or vegetable dish. The versatility of this amazing seasoning is such that you should use it whenever you use salt and pepper. It adds no flavor of its own—simply restores *natural* flavor. Ac'cent (pure monosodium glutamate) is a pure vegetable substance that is natural to almost all foods at one time or other. So when *you* add Ac'cent, you're simply supplementing an inherent quality which is frequently lost in cooking, storage and "holding over."

Variety items on your menu *taste* better ...*sell* better when you add Ac'cent to their preparation. Really *delicious*, low cost-high profit dishes can help greatly to maintain your usual standard of high quality food *and* a necessary margin of profit. And there's *one way* to make these necessary dishes *so good* that they become *favorites*, in constant demand. Start adding Ac'cent to the preparation of your meat loaves, croquettes, fricassees, soufflés, hashes, stews and rice dishes. For Ac'cent brings out—and holds—the natural flavor already in foods, especially those with bland and subdued flavors. With Ac'cent, there will be no more dull, uninteresting variety dishes on your menu. Every item will help you build a reputation for good food.

Try Ac'cent soon. See how your customers notice the difference right away, without even realizing why. Yes, flavor's the keynote to success. It's flavor that brings in customers ...and it's Ac'cent that brings out flavor.

Ac'cent®
PURE MONOSODIUM GLUTAMATE
...makes good food taste better!



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Follow the example of other leading American hospitals – let the warm, glowing **COLORS** of **BOLTA LAMINATED TRAYS** add cheer and appetite-appeal to patients' meals. Choose from **BOLTA**'s 36 sparkling color-and-pattern combinations, made richer by **BOLTA**'s exclusive lamination process . . . a lamination process that fuses seventeen (17) separate layers to give up-to-ten-times as much strength . . . as much as two-to-six years of longer wear. That's why **BOLTA TRAYS** cost less in the long run – much less.

Only BOLTA gives you such outstanding durability in patterns and colors.

- Non-porous, satin-smooth surfaces
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- Lightweight, noiseless, easy to handle
- Washable in mechanical dishwashers
- Will not warp, split or stain
- 8x10, 10x14, 12x16, 14x18, 15x20



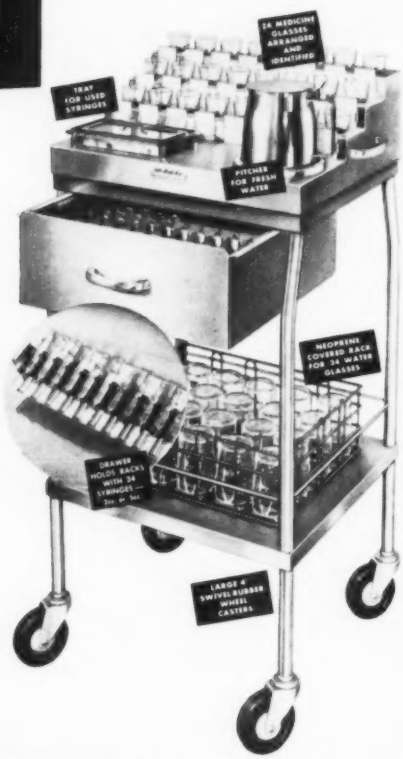
Also Famous Boltalite Hard Rubber Trays in Sizes 12 x 16 and 14 x 18
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The **BOLTA** *Company*
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Planning to Re-decorate? Specify **BOLTAFLEX** *for booths and furniture,* **BOLTA-WALL** *for interiors*

GIVE YOUR HOSPITAL THE ADVANTAGES OF THE

Medi-Kar Experience-Proved Medication System...



No other medication cart can save you up to 53% in medication time . . . make such easy, safe deliveries to bedside . . . save nurses so much time and work!

Let the more than 600 hospitals using over 2000 Medi-Kars tell you why they adopted the Medi-Kar, the "Cadillac" of all medication carts, for their nursing service. These leading hospitals found from *experience* — no other medication system offers the practical advantages of safety and convenience for the patients with such great savings in time and work for their nurses!

With the Medi-Kar System one nurse can perform the duties of many — by preparing and administering the medications for a complete nursing section at once. No wasted trips back-and-forth for supplies. Up to 48 complete medications —24 oral and 24 hypos, each safely identified, plus all needed supplies roll easily and quickly to the patient's bedside.

Act today — learn more about how the Medi-Kar *Experience-Proved* Medication System will benefit your hospital — send for complete details!









1 24 complete oral medications are prepared at one time. Both the medicine glasses and the patients' medicine cards are placed in permanent holders for accurate, safe identification.

2 24 loaded hypodermic syringes are placed in special racks. Each syrings protected by an acceptable safe aseptic technique and properly, safely marked by the patient's own medicine card.

3 The racks slide into the drawer for transit. Syringes are held level and firm by *both* spring clips and sponge trough. No danger of medication leakage or sponges falling off. Medication and cards remain *precisely* as placed until ready for the patient.

4 The Medi-Kar rolls to the patient's bedside and the nurse selects either oral or hypo medication without delay. Everything she needs is provided — even fresh water, glasses and a tray for soiled syringes. This procedure is repeated for as much as an entire nursing section with complete safety and efficiency.

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Please send me complete facts as to how the Medi-Kar Experience-Proved Medication System will benefit my hospital.
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Hospital.....
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Compare, feature by feature...and you'll choose

TOMAC OVERBED TABLE



The Tomac Table's single-pedestal design permits easy use with wheel chair.



Note how single-pedestal also permits use between bed rails.



Large combination mirror and book rest. Removable tray. Formica top affords smooth writing area.



Ruggedly-built. Withstands even unusual weight and stresses.

Stronger than either of two other leading makes by actual weight tests. From its chip-proof, stain-proof Formica top to its steel base, the TOMAC OVERBED TABLE is built for years of rugged service.

Beautifully designed and soundly engineered. Can be used on either side of bed. Single-pedestal construction for versatility. Your choice of a wide variety of attractive decorator colors . . . or any solid color you specify.

Quickly adjustable by nurse or patient to any height between 29" and 44".

May we send you
an illustrated booklet giving the complete story of the TOMAC OVERBED TABLE.



now...



white edge soles end scuffing and marring of floors. Enhance beauty of shoes

A SIMPLE, EFFECTIVE STEP IN COMBATING STATIC ELECTRICITY IN OPERATING AND DELIVERY ROOMS!



Specifically designed for nurses and physicians. Good looking, comfortable, moderately priced.

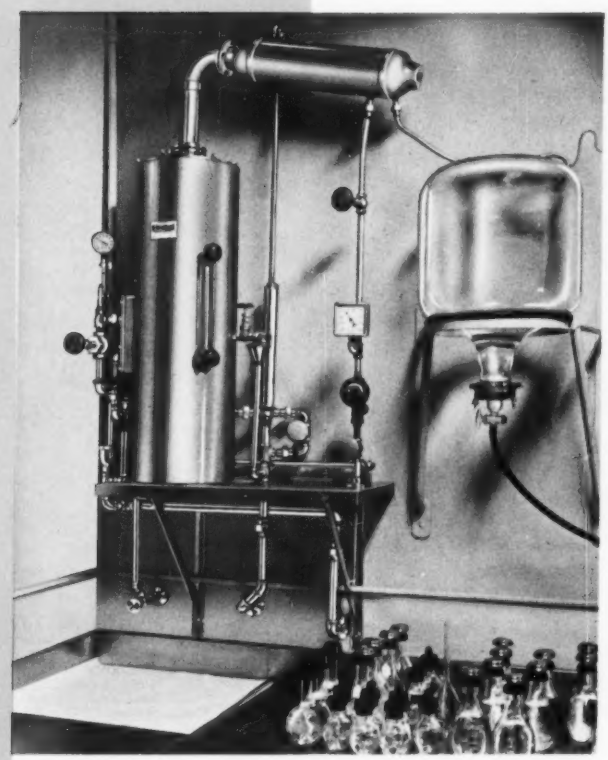
TOMAC CONDUCTIVE SOLE SHOES

Static Electricity is a constant threat in operating and delivery rooms—unless complete protection becomes standard procedure. Conductive flooring is a logical first step towards complete protection. An equally important second step is needed to complete the safety cycle—conductive sole shoes.

Tomac Conductive Sole Shoes provide the vital protective link between personnel and the conductive floors upon which they stand. They are made by International Shoe Company and distributed by **AMERICAN** to hospitals throughout the country. May we send you the complete details?



How THE CAMBRIDGE CITY HOSPITAL puts Barnstead pyrogen-free water to use



One of a pair of Barnstead "Q" Stills at Cambridge City Hospital Central Supply. Each still produces 5 gallons of pure distillate per hour. Both stills in constant daily use on a 7 a.m. to 9 p.m. schedule and have required practically no attention and only infrequent cleaning.

THE Cambridge City Hospital, Cambridge, Mass., like most hospitals the world over depends on the sure, safe way . . . the Barnstead way to get the purest, pyrogen-free, distilled water for all of its hospital requirements . . . automatically . . . when they need it . . . and in whatever quantity they require.

IN THE LABORATORY where complete freedom from organic and inorganic solids, bacteria and dissolved gases is needed, Barnstead delivers water of the highest purity. Research work is carried on precisely because Barnstead always produces distilled water of constant, unvarying quality.

IN THE CENTRAL SUPPLY where even flasks, bottles, needles, tubing, trays, etc., are washed and rinsed in distilled water, the Cambridge City Hospital finds that Barnstead Distilled water is the time-tested and proven way to achieve optimum results.

IN THE PHARMACY in the compounding of prescriptions . . . where absolute purity is vital . . . Barnstead pyrogen-free water eliminates any possible variable. This record of accomplishment is the result of 75 years of specialized experience in water still design. For complete information, write for your copy of Bulletin 116 today!

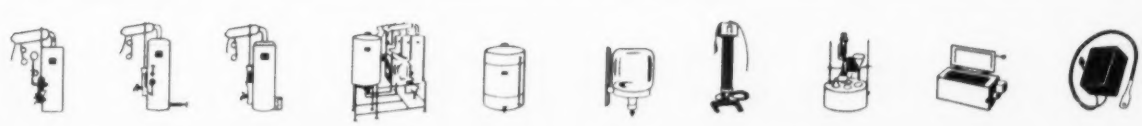
OVER 200 DIFFERENT STYLES AND SIZES

A STILL FOR EVERY HOSPITAL — FOR EVERY DISTILLED WATER REQUIREMENT

27 Lanesville Terrace
Forest Hills, Boston 31, Mass.

75 Years of Progress in Pure Water
1878 1953

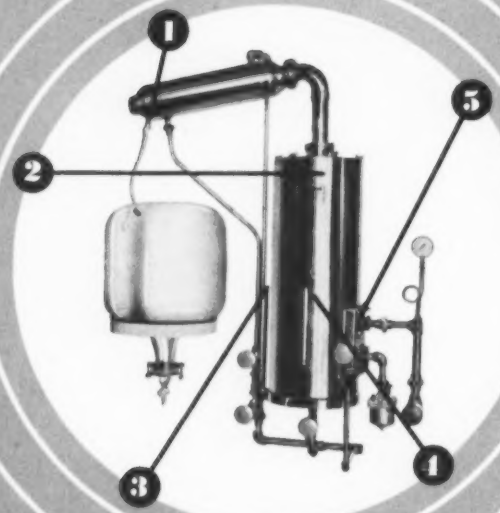
Barnstead STILL & STERILIZER CO.



Here is why

BARNSTEAD STILLS PRODUCE THE *Purest* DISTILLED WATER





1 Barnstead self-cleaning, counter current, horizontal condenser effectively separates and expels gaseous impurities. One of the reasons why Barnstead distilled water is always pure.

2 Spanish Prison Baffle within the evaporator is exclusive with a Barnstead "Q" Still. This important feature scrubs the vapors rising from the evaporator to trap and strip out pyrogens. Modern hospitals, blood banks, and practically all pharmaceutical manufacturers insist on this time-tested safety feature.

3 Constant level control has open hot well to expel gasses from the preheated feed water.

4 Evaporator is wide and deep. Scientifically designed for long vapor travel at low velocity. Ample steam disengaging space above water level so that vapors rise slowly and lazily. Prevents entrainment at the outset.

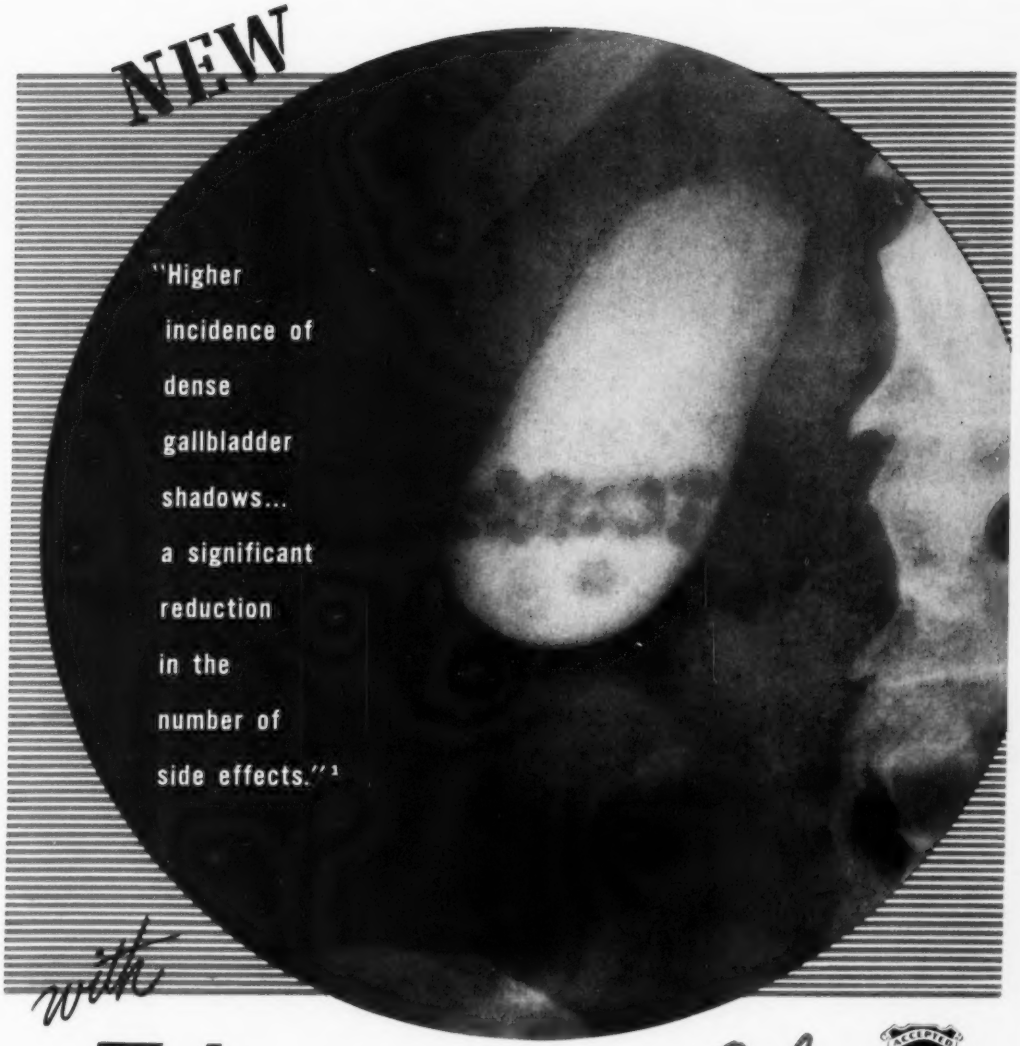
5 Easy to clean. Heating coil is mounted on removable plate on side of evaporator so that coil and evaporator interior are easily accessible for cleaning. With Barnstead design, daily cleaning is never required. Under average conditions Barnstead Stills stay in service for months between cleanings.

Barnstead
STILL & STERILIZER CO.

27 Lanesville Terrace
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Boston 31, Mass.

75 Years of Progress in Pure Water
1878 1953

NEW



"Higher incidence of dense gallbladder shadows... a significant reduction in the number of side effects."[1]

with

Telepaque®

Brand of IODOPANOIC ACID

FOR Oral CHOLECYSTOGRAPHY

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

"Telepaque produced approximately 35 per cent greater opacification of the gallbladder than iodoalphionic acid. This, we believe, constitutes an improvement of considerable significance . . . 40 per cent fewer patients required a second dose of the opaque medium . . . a very real improvement . . . Among 100 patients who received the compound, none experienced emesis, only a few were nauseated (mostly of a very slight nature), and the great majority had no symptoms of any kind whatsoever."[2]

Telepaque is 3-(3-amino-2,4,6-triiodophenyl)-2-ethylpropanoic acid containing 66.68 per cent iodine in organic combination. Recommended dose: 3 Gm. (6 tablets). Optimum shadow occurs 12 to 15 hours after administration.

SUPPLIED
in 0.5 Gm. tablets — envelopes of 6 tablets.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

1. Dunne, E.F., Jensen, E.H., and Hughes, C.R.: Cleveland Clin. Quart., 18:98, Apr., 1951.
2. Morgan, R.H., and Stewart, H.B.: Radiology, 58:231, Feb., 1952.

Telepaque, trademark reg. U. S. Pat. Off., brand of iodopanoic acid [3-[3-amino-2,4,6-triiodophenyl]-2-ethylpropanoic acid]

FABRIKATORS'

RESPIRATOR

The hospital type respirator with PROVEN advantages



SPIRATWIST Plastic Collar — fits all respirators — all neck sizes. Has fully adjustable tracheotomy bar. Disposable — it provides maximum comfort at lowest possible cost.



SPIRATWIST Plastic Armports fit all respirators. Opens wide with one hand—locks automatically when closed. Disposable—use as supplementary catheter openings as required.

FABRIKATORS' RESPIRATORS provide a combination of time-tested and advanced respirator features—unobtainable in any other tank-type respirator. (1) Every respirator is factory-equipped with the original "Spiratwist" plastic collar and fully adjustable tracheotomy bar. (2) EIGHT armports — with the new plastic armports optional at added cost. (3) NEW, "micrometric" valve controls, located beside observation windows, reduce noise — provide hair-line adjustment of pressures with both patient and pressure gage in full view. (4) NEW, adjustable headrest is self-tilting to provide new freedom of head motion — folds up and away for compact storage. (5) NEW, swing-type, head end clamps — adjustable to compensate for wear on head gasket — eliminate periodic replacement. (6) Self-aligning cot returns automatically to proper closed position. (7) Bed may be elevated, rotated — or foot end tilted, without any adjustment of front legs. (8) Entire unit may be wheeled about freely while so tilted or rotated. Only FABRIKATORS' respirators have ALL these important features.



CHESTPIRATOR (portable) Efficient, compact, fully equipped. A self-contained metal unit with BIG respirator features. Plastic (sleeve type) armports, adjustable bed angle and self-tilting headrest. Spiratwist collar.

RESPIRAIR (portable) Plastic Respirator. Compact power unit and plastic chestpieces in 6 sizes. Unique, plastic diaphragm maintains high pressures—makes the Respirair ideal for transportation or treatment of your recovering patients.

(9) Conversion to a TWIN IRON LUNG is easily accomplished by your own personnel—requiring only the purchase of an extra collar and headrest.

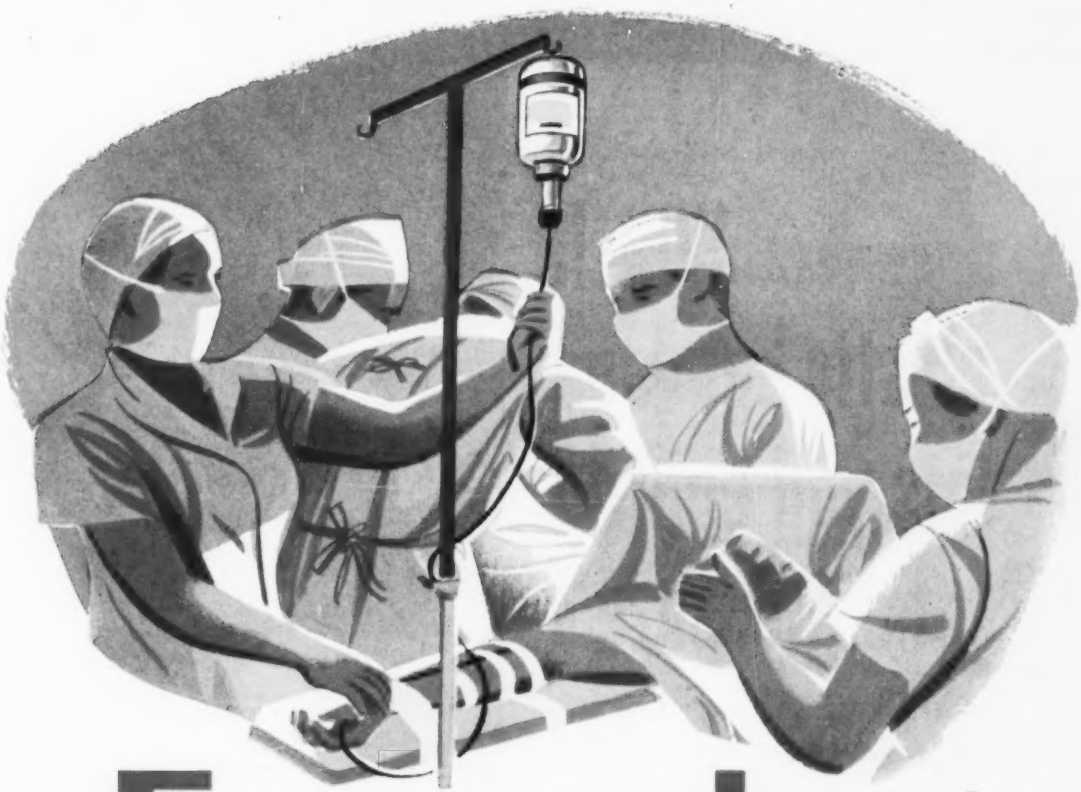
Fabrikators' IRON LUNG COMPANY OF AMERICA INC., OF MASS.

Nineteen Walnut Street West Roxbury 32, Mass.

LICENSEE AND SELLING AGENT — IRON LUNG CO. OF AMERICA

The Fabrikators' Respirator is accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association and is listed under re-examination service of the Underwriter's Laboratories. ALL types shown are easily converted to hand operation.

AT THE FIRST SIGN OF CIRCULATORY FAILURE



Expandex®

(DEXTRAN) INJECTION 6%

Restores Effective Blood Volume

Given at the first indication of blood pressure drop, Expandex reverses the chain of events by expanding the effective blood volume and thereby overcoming the impending circulatory failure.

Because of its desirable osmotic behavior, Expandex (6% dextran in normal saline solution) is effectively employed for the treatment of shock due to hemorrhage, burns, trauma, and surgery. In hemorrhage, it can serve as the sole replacement fluid, provided the blood loss does not exceed 35 per cent.

Expandex is sterile, nonpyrogenic, notably nonallergenic and nonantigenic and is not stored in significant amounts in the body. It does not carry, therefore cannot transmit, the virus of hepatitis. Expandex is compatible with all blood groups, and does not interfere with blood typing, crossmatching, or Rh determinations following its administration. It is liquid and stable at room temperature, hence is ready for immediate administration. Refrigeration is never required.

Injection Expandex, the first clinically acceptable dextran produced in the United States, is supplied in 500 cc. bottles, with or without a Sterile Administration Set. Available through regular sources of supply.

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C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION • 260 MADISON AVENUE, NEW YORK 16

NEWS ABOUT A BAUER & BLACK PRODUCT

Which elastic bandage lets you control the pressure?

The bandage on the left is TENSOR—woven with live rubber threads

You, doctor—not the *bandage*—control the pressure when you use a Tensor Elastic Bandage.

You apply *low* pressure as easily as high pressure.

You obtain *uniform* pressure over the entire bandaged area.

You apply pressure with substantially *less* danger of hyperconstriction of the blood vessels. And with substantially *greater* mobility for your patient.

Moreover, you do not have to adjust Tensor as swelling goes up and down—it adjusts *itself*.

The picture tells why Tensor does so much for you in the treatment of vascular and muscular disorders. As you see, it is more than *twice* as elastic as old-style bandages. It is woven with *live rubber threads*—not just cotton.

Isn't that the kind of elastic bandage, Doctor, that you want *your* patients to wear?

TENSOR®

ELASTIC BANDAGE

Woven with live rubber threads

BAUER & BLACK

Division of The Kendall Co.
309 West Jackson Blvd., Chicago 6, Ill.



Under equal tension

Tensor stretches approximately twice as far as old-style cotton bandages. And Tensor will snap back smoothly to its original length. That's why Tensor gives you greater control of pressure, reduces constriction, increases your patient's mobility.

CLEANLINESS
NEATNESS
CONVENIENCE
ECONOMY

"In the Bag"

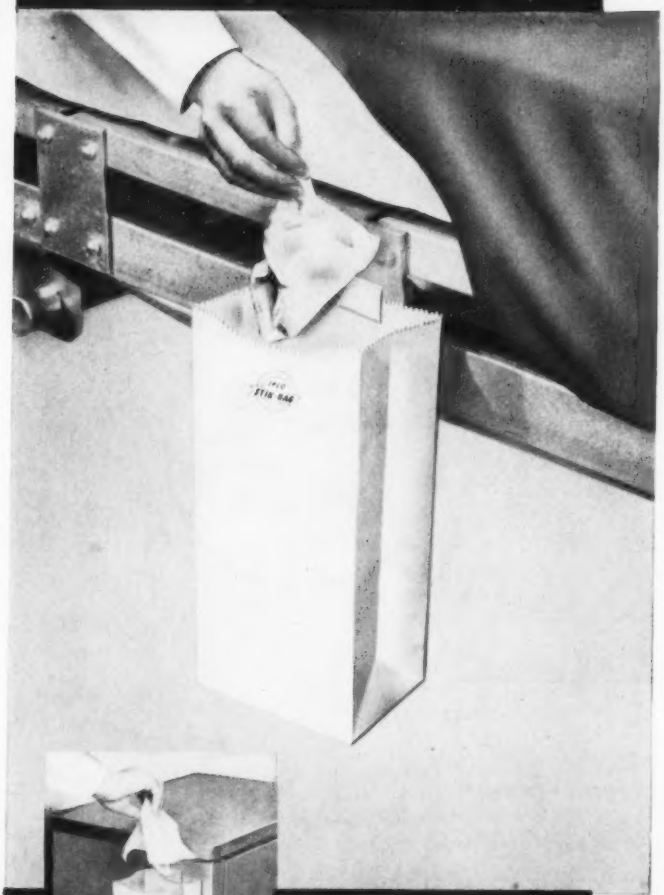
WITH THE NEW IPCO

STIK-BAG

PAT. PEND.

for BEDSIDE WASTE-DISPOSAL

- Eliminates Costly, Cumbersome Wire Frame Holders.
- Eliminates Use of Unsightly Brown Paper Bags.
- Eliminates Pin-Hole Damage to Sheets.
- Eliminates Wasteful Use of Adhesive Tape.

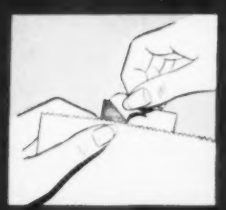


Here is still another popular item in IPCO's long line of efficient overhead-cutting items! Aside from its many practical advantages, the IPCO "Stik-Bag" will pay for itself in savings on linens alone—so generally abused by use of damaging, tearing safety pins.

INSTITUTIONAL PRODUCTS CORP.
161 Sixth Avenue
New York 13, N. Y.

INSTITUTIONAL PRODUCTS IPCO CORPORATION

Sticks Firmly to Wood, Metal, Glass, Formica, Etc.
Peels Off Easily Without Marring Surface



1 - Slowly peel off protective white paper from tab.



2 - Apply cohesive tab to any smooth surface.

SEND FOR YOUR FREE SAMPLE TODAY!

Institutional Products Corp.
161 Sixth Ave., New York 13, N. Y.

Gentlemen: Please rush me samples and prices of "Stik-Bag"

Institution_____

Address _____ City _____ State _____

Purchasing Executive _____

IT'S NEW...

The Ideal Mono-top Deck

A significant advancement in the design and construction of Ideal Food Conveyors...

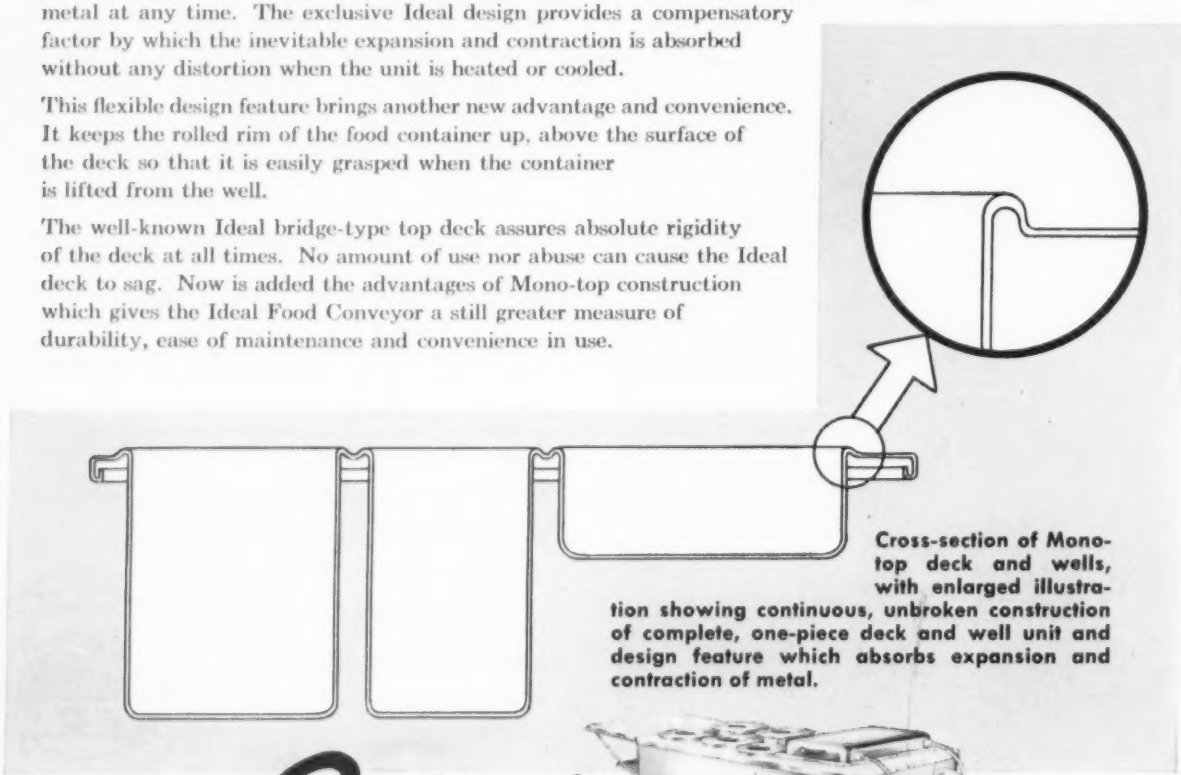
There isn't a joint, crevice, cranny—nor crack in the new Ideal Mono-top deck now standard equipment on Ideal Food Conveyors.

The Ideal Mono-top deck literally is in one piece. Container wells and top deck are constructed from a solid sheet of stainless steel. The entire deck and well unit presents only smooth, unbroken surfaces. Not even microscopic hidden or inaccessible interstices exist anywhere.

The Ideal Mono-top Deck does not buckle, when the unit is heated. There is no warping of the metal at any time. The exclusive Ideal design provides a compensatory factor by which the inevitable expansion and contraction is absorbed without any distortion when the unit is heated or cooled.

This flexible design feature brings another new advantage and convenience. It keeps the rolled rim of the food container up, above the surface of the deck so that it is easily grasped when the container is lifted from the well.

The well-known Ideal bridge-type top deck assures absolute rigidity of the deck at all times. No amount of use nor abuse can cause the Ideal deck to sag. Now is added the advantages of Mono-top construction which gives the Ideal Food Conveyor a still greater measure of durability, ease of maintenance and convenience in use.



Cross-section of Mono-top deck and wells, with enlarged illustration showing continuous, unbroken construction of complete, one-piece deck and well unit and design feature which absorbs expansion and contraction of metal.





Ideal
HOSPITAL EQUIPMENT
Found in Foremost Hospitals

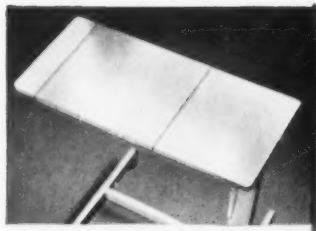
MADE ONLY BY THE Swartzbaugh MANUFACTURING COMPANY
ESTABLISHED IN 1884
TOLEDO 6, OHIO

Ideal Food Conveyors
Special Diet Trays
Hot Pack Heaters
Ideal Terminal Sterilizer
Blood Bank Guard
Bassinet Basket

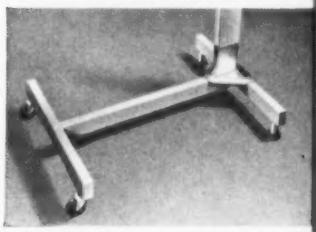
HIA HOSPITAL INDUSTRIES ASSOCIATION

WRITE FOR CATALOG AND COMPLETE DATA

Distributed by the Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Company, Los Angeles, and San Francisco. In Canada: Canadian Fairbanks-Morse Company.



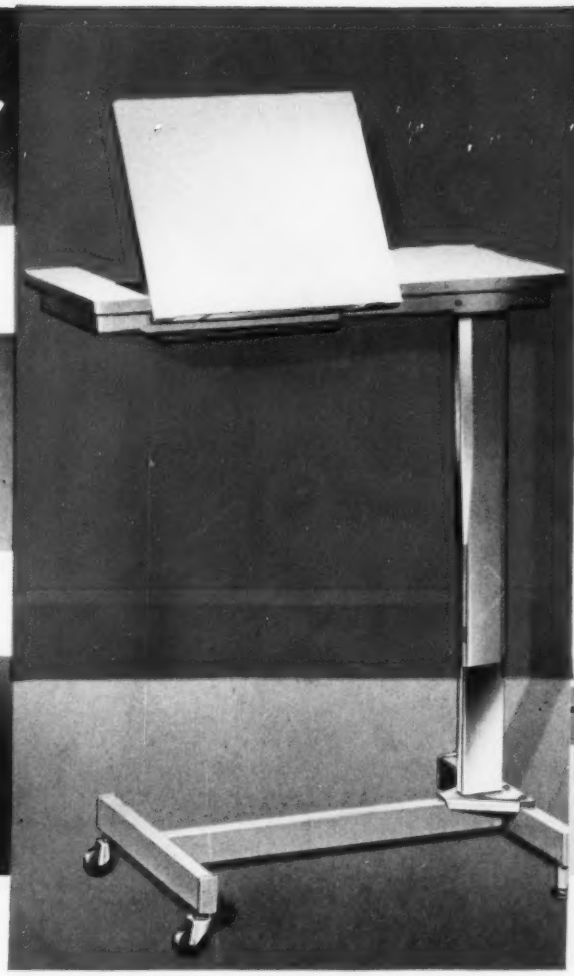
Ever see such a *big* top on an overbed table? 14¼ x 31¼ inches! Its 5-ply laminated base is covered with tan and grey Zalmite. Resists damage by heat, cold and spilled liquids.



Note the balanced spread of this sturdy base. And the extra bracing clamp where base meets pedestal upright. Note, too, that base is equipped with casters for easy moving; glides for stability.

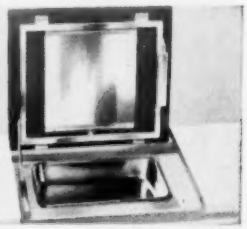


Double hinged center-section permits full use of table from either side of the bed. Patient has advantage of using full section as book or magazine rest, and of a larger mirror when used as a vanity.





The full width, movable center section will hold a large magazine or a folded newspaper. Note the flat surface area at right of rack, ample for articles in use when center section is raised.



This big stainless steel tray gives the patient room for personal articles, writing materials, etc. This tray is also available finished in porcelain enamel (F-884). Note, the large size of the mirror.



To raise or lower, patient simply presses on hand grip, and the counterbalanced table top adjusts to one of 15 positions, graduated 1 inch apart. Can be lowered to 29¼"—for use by patient seated in chair.



Only Simmons Overbed Table has all these features!

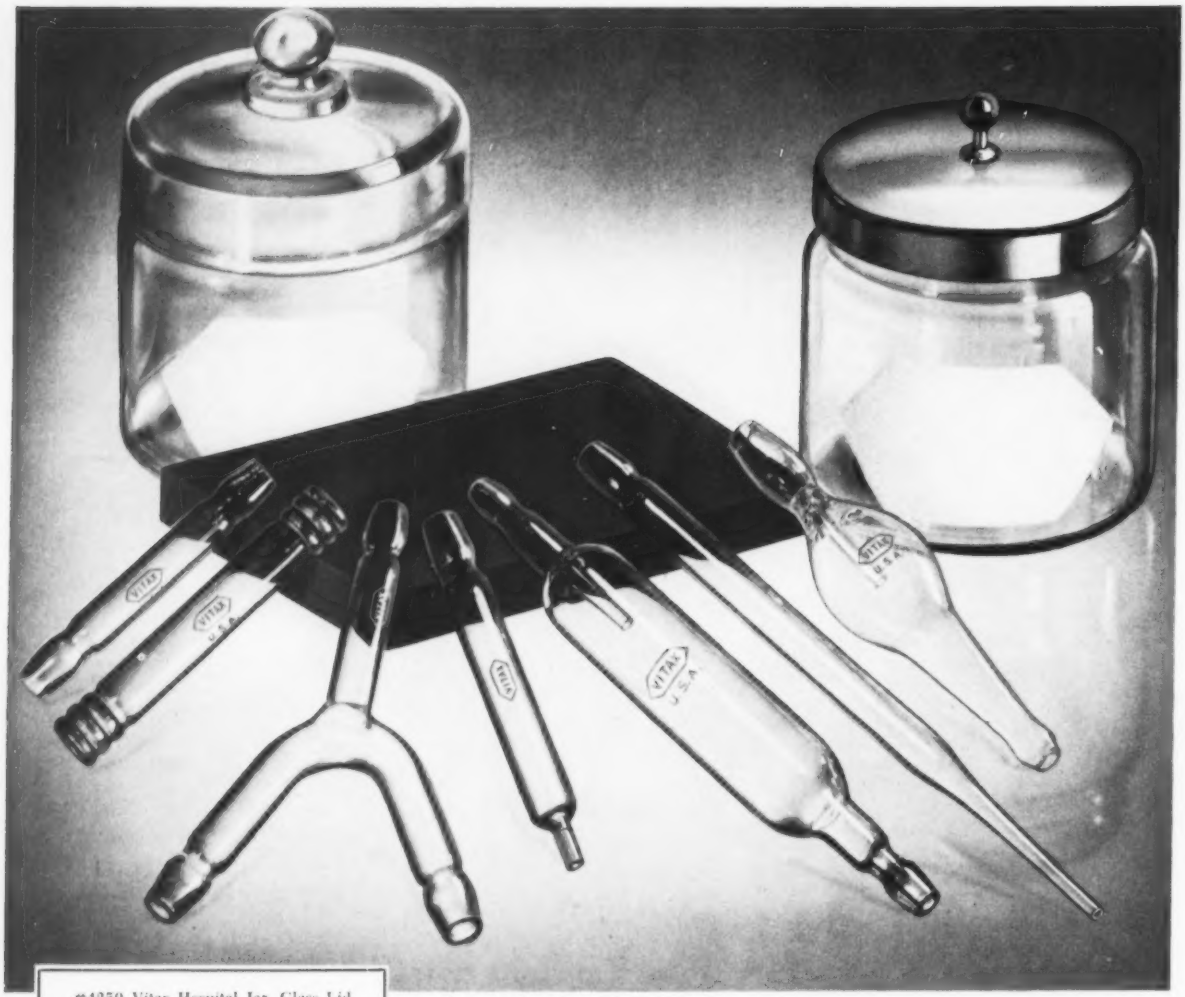
Illustrated here are the 6 outstanding features of Simmons new single pedestal overbed table—F-885. *Compare it with any other table.* You'll soon see why we say it offers more value in construction features, sturdiness, utility and quality.

See this new, improved Simmons Overbed Table at your hospital supply dealer's showrooms, or at any of the Simmons display rooms whose addresses are listed below. Or, write today for complete details, including quantity prices.

SIMMONS COMPANY
HOSPITAL DIVISION

Display rooms:

Chicago 54 Merchandise Mart · San Francisco 11 295 Bay Street · New York 16 One Park Avenue · Atlanta 1 353 Jones Avenue N. W.
Dallas 9, 8600 Harry Hines Blvd.



#4250 Vitax Hospital Jar, Glass Lid
#4260 Vitax Hospital Jar, Metal Lid (Sand Blast Patch for Marking)
#3640, #3660 Vitax Connecting Tubes Straight • #3690 Connecting Tube, V-shape • #3820 Irrigating Nozzles, Sim's • #3920 Observation Tube #3930 Murphy Saline Tube, with bulb and vent • #3946 Drip Tube

VITAX means safety you can trust . . . plus savings

That every hospital must put safety before economy goes without saying. How to keep costs down in the face of rising costs without sacrificing standards is a real problem.

One way many hundreds of hospital superintendents are meeting this challenge is by specifying Glasco Products' VITAX Glassware.

Here is why

Every piece of Glasco Products' hospital glassware is made of very heavyweight glass. Specially made for hospitals, it is better able to withstand hard treatment in handling, use, and sterilizing.

VITAX glassware is made of glass that withstands corrosive action. It will not discolor or become cloudy after repeated sterilization.

The VITAX trademark appears on each piece of VITAX glassware. Look for it; it is your assurance that you are getting the best in surgical glass. Specify VITAX always and be sure of getting safety . . . plus savings. Consult your hospital supply house.

Free Catalog

If you don't have our catalog write for a free copy and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

induce complete relaxation with

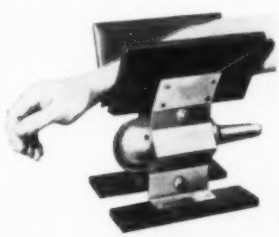
NIAGARA CYCLO-THERAPY



NIAGARA TRIPLE TABLE



HAND UNIT *Small, compact unit used over entire body. Possesses amazing penetrating power.*



ORTHOPEDIC ADAPTER *An attachment for the Hand Unit. Offers comfortable support for the limb while directing deeply penetrating action to knee, ankle, calf, wrist, elbow, etc.*

Niagara's three-directional action penetrates deeply . . . gently . . . into the body to exercise, comfort and exhilarate. It is unsurpassed in its ability to provide the finest manipulation of skin, tissues and muscles.

Niagara, too, is effective in the treatment of hypertension, circulatory deficiences, and cartilaginous and bony overgrowths.

Principle of operation is vastly different . . . one that offers a range of effectiveness and depth of penetration unmatched by vibratory mechanisms.

To acquaint yourself with Niagara Cyclo-Therapy, write TODAY for attractive informative catalog.

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Why a thermostat in every room is a

MARK OF A MODERN HOSPITAL



76° **In room 508,** this active youngster is recovering from minor surgery. Because this hospital has Individual Room Temperature Control, the temperature in this room can be set at 76°—assuring a proper room environment even if he hops out of bed or kicks off his blankets.



70° **In room 608,** this patient's physician feels 70° will help speed her recovery. With a Honeywell Hospital Thermostat in each room, physicians can make room temperatures part of their prescription.

Physicians in modern hospitals that have Individual Room Temperature Control can prescribe the *exact* room temperature needed to speed each patient's recovery. This medical practice can be followed *only* if the hospital has a thermostat in every room—for no other method can compensate for the varying effects of wind, sun, open windows and other variations of internal load in each room.

That's why Individual Room Temperature Control should be an important consideration if you plan to build or modernize your hospital. Of course, the most economical time to install this modern system is when the hospital is being built. For, contrary to most beliefs, Individual Room Temperature Control is not expensive — most installations will cost only between ½ and 1% of the expenditure per bed.

For complete facts on Honeywell Controls for your hospital, call your local Honeywell office—there are 104 in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-6-124, 351 E. Ohio Street, Chicago 11, Ill.



First thermostat specially designed for hospitals!

You get *all* these features only on a Honeywell Hospital Thermostat:

- *"Nite-Glowing dials"* permit inspection without disturbing patients.
- *Magnified numerals* make readings easy to see.
- *New Speed-Set control knob* is camouflaged against tampering.
- *Air-operated;* requires no special connections.
- *Lint-Seal* insures trouble-free, dependable operation.

MINNEAPOLIS **Honeywell**

First in Controls

the new OHIO

AUTOMATIC MOIST-PAC HEATER

FOR POLIO AND OTHER PACK THERAPY

- **Automatic** temperature control
- **Automatic** moisture control
- Peaked cover . . . prevents wetting of packs by condensation
- Visual "finish" signal
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- Large, easily removable container with heat-resistant handles
- Plugs into standard 115-volt A. C. convenience outlet
- Listed by Underwriters' Laboratories, Inc.



Portable Moist-Pac Heater mounted on Bakelite feet. Model 740.



Portable Moist-Pac Heater mounted on Sterilbrite floor stand. Model 741.

Now any hospital staff can easily administer hot moist packs that are always temperature-correct . . . that always contain just the right amount of moisture. Packs may be prepared and left right in the heater. Temperature and moisture area automatically controlled so that packs are always ready for application . . . may be applied directly to the patient. The roomy, removable container holds sufficient packs to completely pack an adult. The Moist-Pac Heater may be used right at the bedside — or wherever there is an electrical outlet. Effective for any treatment where hot moist packs are required.

send for information today!

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Ohio Chemical & Surgical Equipment Co.
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Please send me Bulletin No. 2158 on the new OHIO Moist-Pac Heater ☐
Price data ☐ Delivery information ☐

Name.....

Title.....

Address.....

City..... Zone..... State.....

Name of hospital.....



...if you want to see the heating element

You won't see any finned pipe heating element once you put in Dunham Baseboard. You know it's there, of course, by the way it performs.

But, once installed, Dunham Baseboard shows only straight, smooth, unbroken horizontal lines . . . no heating fins, no pipe, no piping connections are visible through air openings.

Dunham's unique, one-piece, smooth-surfaced front cover is easy to clean. Since it extends clear to the floor, there's no "cleaning under" problem, either.

For a better looking, better heating, cleaner installation—better find out more about Dunham Baseboard.



Send for Free Bulletin

See how Dunham Baseboard fits into a wide variety of industrial, commercial, residential and institutional buildings. Complete data on materials, construction and capacities. For your free copy of Bulletin No. 639-D-19, write to C. A. Dunham Co., 400 W. Madison St., Chicago 6, Ill.

DUNHAM BASEBOARD HEATING

DUNHAM 1903-1953 *Quality first for fifty years*

ANOTHER QUALITY PRODUCT OF C. A. DUNHAM COMPANY • CHICAGO • TORONTO • LONDON

EXTENDED ANOTHER 30 DAYS

GARLAND'S

OLD RANGE REPLACEMENT

MONTH CONTINUES THROUGH JUNE

See Your Garland FOOD SERVICE EQUIPMENT DEALER—Today!



THINK! HOW LONG SINCE YOU CHECKED YOUR OLD RANGES?

If your chef is struggling along with old ranges, look, then compare them with the efficiency of the newest Garland. You'll find your old ranges are actually *costing you money!* And that new Garlands will *soon return their entire cost!*

The new Garland does a better cooking job at lower fuel cost—lets your chef increase the output of your kitchen.

So see your Garland food service equipment dealer now. Let him show you why *Garland-built is better built*—why you'll be better off with gas—the ideal fuel. Plan to buy—during "Old Range Replacement Month." ***All Garland units can be furnished in Stainless Steel and can be equipped for use with natural, manufactured or L-P gas.***

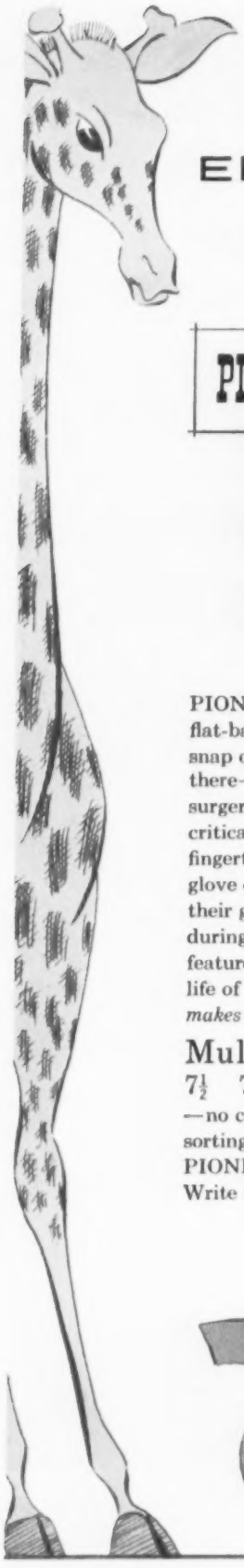
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HIGHER tensile strength and greater ELONGATION withstand more sterilizations at **LOWER** costs



PIONEER ROLLPRUF® Surgical Gloves

PIONEER Rollprufs' flat-banded beadless wrists snap over sleeves and stay there—no annoying roll-down during surgery... no time-wasting adjustments at critical moments. Sheer for extreme fingertip sensitivity, *tough* enough to cut your glove costs to a few cents per pair per use, their greater elasticity is less constricting during long operations. Exclusive banding feature reduces tearing, adds to the extra long life of these top quality surgeons gloves, *makes your glove dollars go further.*

Multi-Size Markings

$7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$ $7\frac{1}{2}$

—no color code to memorize—speed up glove sorting, cut labor costs. Available exclusively on PIONEER surgical gloves *at no extra charge.* Write today for complete information.

Specifications:

Average 5000 lbs. tensile.

850% elongation.

—both in excess of Federal Specifications ZZ-G-421-A.

No perceptible loss of tensile strength in first ten sterilizations.

100% factory inspection to insure complete protection of both doctor and patient.

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Small Hospital Questions

Who Pays for Uniforms?

Question: Do most hospitals now furnish nurse's aides and other personnel with uniforms and uniform laundry service, or are employes required to buy their own uniforms?—K.S.P., Pa.

ANSWER: It is increasingly the practice in hospitals today to furnish uniforms for employes without charge, and to launder employes' uniforms, also without charge to the employe. This is in line with prevailing practice in most industries employing uniformed attendants. Experienced personnel officers believe the practice permits better control of the appearance of uniformed employes, in addition to the return in employe good will.

The practice is not by any means universal among hospitals, however. Many institutions which have recently switched to an all cash pay roll basis, instead of the cash plus perquisites basis that prevailed for so many years in the hospitals, are charging employes for uniform laundry service and requiring them to purchase their own uniforms. "We have discussed the need for laundering nurse's aides' uniforms," one administrator said recently, "feeling that many of them would be more tidy if we did this. Our aides wear the standard gray uniforms that may be purchased in most department stores. We give them 'ward aide' badges free of charge but are making a charge for laundering, if the aides do not have their uniforms laundered outside the hospital, as most of them now do. The principal problem with us is that many aides cannot afford to buy enough uniforms to keep them looking clean and smart."

Full-Time Pathologist?

Question: Is a hospital with an average of 72 patients a day large enough to justify the employment of a full-time pathologist? We are also interested in the question of compensation for the pathologist.—J.H.Z., Utah.

ANSWER: While the nature of the professional work that is done in a hospital, as well as the number of patients, must be considered in determining the amount of work that would be done by a pathologist, it does not seem likely that the services of a full-time pathologist would be justified in this case. The number of qualified pathologists is sharply limited, and it would appear that valuable professional time and ability might be lost by a full-time pathologist in a hospital of this size. It should be possible to make some arrangement with the department of pathology in one of the larger hospitals in the area to share the services of the pathologist. Under these arrangements, the pathologist may come to the hospital once or twice a month to discuss cases with the staff and review laboratory technic. Meanwhile, surgical tissues may be sent to the pathologist routinely for examination. Technicians may also be referred to the pathologist for training under such an arrangement.

The commonest method of compensation for hospital pathologists today is probably the commission or percentage arrangement under which expenses of the department are paid out of its revenue, and the excess of income over expense is divided between the pathologist and the hospital. Salaries are still regarded as the most satisfactory method of compensation by a number of hospital people, but many pathologists consider that it is unprofessional, or even unethical, to accept a salary. In recent years there have been numerous articles in the hospital literature about the method of compensating pathologists, radiologists and anesthesiologists.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Figuring Cubic Content

What is the usual method of figuring cubage of buildings to arrive at the cubic foot cost?—B. T., Calif.

The American Institute of Architects uses the following standard method of calculation:

"*Definition.* The cubic content (cube or cubage) of a building is the actual cubic space enclosed within the outer surfaces of the outside or enclosing walls and contained between the outer surfaces of the roof and 6 inches below the finished surfaces of the lowest floors.

"*Interpretation.* The foregoing definition requires the cube of dormers, penthouses, vaults, pits, enclosed porches and other enclosed appendages to be included as a part of the cube of the building.

"It does not include the cube of courts or light shafts, open at the top, or the cube of outside steps, cornices, parapets, or open porches or loggias."
—A.H.R.

1953 Outlook for Polio

What is the polio outlook for 1953?—J. B., Ill.

Scientists are now planning the first field trials of a polio vaccine, and manufacturers are producing the blood fraction, gamma globulin, for limited use as a temporary preventive of paralysis.

Despite this, 1953 will see outbreaks of polio; we cannot count on any startling reduction of cases this year. Reasons: (1) The vaccine is *not* here—it has yet to be tested. (2) Despite every effort of the National Foundation for Infantile Paralysis, the American Red Cross, and government authorities, gamma globulin will be in such short supply it can be given to fewer than 1,000,000 children out of a population of 46,000,000 in the most susceptible age groups. Distribution of gamma globulin will be controlled by the National Research Council; in most communities, the council has reported, local health departments plan to limit distribution to family contacts of known cases, in order to use the small available supply most effectively.

Prescribed for Purity



When doctors and hospitals recommend a carbonated beverage for their patients, purity is a prime requisite. In this light, the following facts obtained from a national survey* are highly significant:

1. *Ginger ale is the type of carbonated beverage most frequently recommended.*
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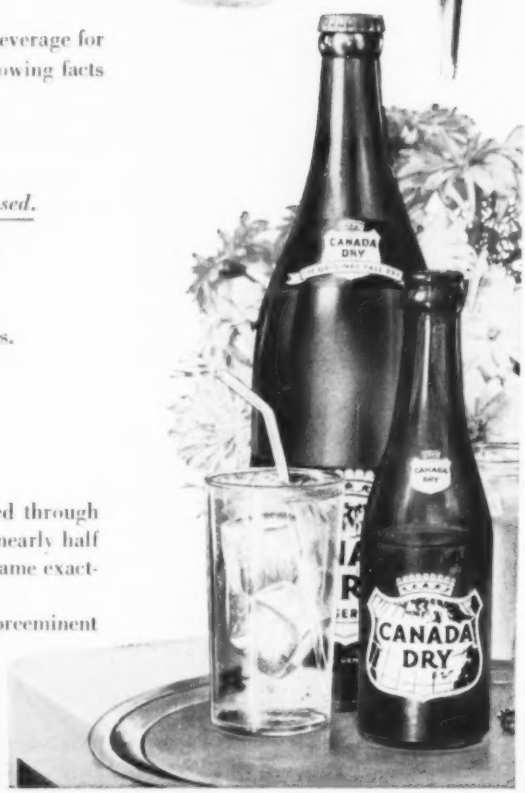
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* to speed up pyloric discharge and augment gastric contractions.

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wire from Washington

APPROPRIATIONS PICTURE

Like virtually every other activity that uses federal dollars, hospital programs already are restricting their operations under relentless administration pressure for reduced spending in the fiscal year starting July 1. In order to scale down their spending in an orderly and efficient manner, the responsible officials start the pruning as soon as it is apparent that cuts are inevitable, and don't wait for the July 1 deadline.

At this writing, as appropriation bills for the various health activities follow their painful paths through Congress, indications are that the purse strings will be loosened only for research. As usual, the (middle-aged and elderly) lawmakers were preparing to allow the cancer, heart and mental health institutes more money than the Budget Bureau thought they needed.

Elsewhere the story is the same—heavy to drastic reductions for the Hill-Burton program, the Public Health Service marine hospitals, the military hospitals, Veterans Administration, the Indian Bureau's medical department. The second and third echelon officials who actually run these facilities took their first budget beatings within their own departments. Then the Budget Bureau's experts found other places to pare down or eliminate. In many cases House and Senate committees also found ways to trim still more.

In a few rare cases—Hill-Burton was one—there was still some hope that funds could be restored on House or Senate floor when the money bills came up for passage.

During several long days of testimony before a House committee, Dr. John Cronin, head of the P.H.S. Division of Hospital Facilities (Hill-Burton) was asked if programs such as Hill-Burton "take some of the spirit out of the people," because the money comes from the federal government. Dr. Cronin's reply, given to a critical if not hostile committee, seems to compress into a few sentences the entire philosophy of the program. He said:

"**I believe** that in a democracy the job to be done is what the people of the country want done and how they want to do it is to be determined by them. I think the Hill-Burton program, at least in my experience with it, which is now approximately four years, is a demonstration of how the federal government, the local community, and the state can get together in a cooperative endeavor to accomplish something which many areas of this country are unable to accomplish for themselves by themselves.

"**I offer** in testimony the fact that this program, with its $542 million appropriated by Congress for distribution to the states, has been matched by the people of this country to the extent of $1,045 million, so that the program today is a program of $1.5 billion. . . .

"**I feel** that if the community wishes to do it that way, that is the community's responsibility and the community's decision. . . . I might add, Mr. Chairman, that this program, in my personal opinion, is probably one of the best defenses there is against any form of what we normally consider to be socialization in the medical area. I think that opinion is shared by the medical leaders of the country and by people of both political-party beliefs."

At the same hearing, Roy Harlow, finance officer for P.H.S., explained to the committee what would happen in some states with split projects if the H-B fund were cut from $75 million to $60 million, as proposed by the Budget Bureau.

He said that about 30 states would be affected, and that in seven of them the total federal money available wouldn't even match the expected federal contribution to the split projects. There would, of course, be no federal money at all to apply to new construction or under-way construction where the split project procedure had not been used. Mr. Harlow listed the seven states and their expected shortages as Arkansas, $323,953; Georgia, $40,480; Kentucky, $210,569; New Jersey, $323,460; Ohio, $180,149; Rhode Island, $72,-147, and South Carolina, $341,724.

Mr. Harlow added: "We are unable at this time to say how many of the states (project sponsors) will be able to find other sources of funds. Certainly I would assume that where there is only a small amount involved they will be able to raise it. In others, I think I am safe in saying they will not be able to do it."

Did this make an impression on the committee? Not much of an impression! It cut the Budget Bureau's recommendation from $60 million to $50 million. This represents a cut of one-third in the amount recommended by the Truman administration. The committee said it was providing the $50 million "primarily because of the 'split technic' of financing, which the committee has been informed is technically legal but is certainly one of the most ingenious ways of pressuring Congress for continued appropriations that the committee has yet encountered." The committee recommended that a detailed survey be made of the program before Congress extends it beyond its scheduled expiration date of June 30, 1955.

Public Health Service's own marine hospitals and special hospitals, such as those for lepers and narcotic addicts, also are looking toward a full year of belt-tightening. A total of $29 million had been asked for them next year in the Truman administration budget, or a $1 million increase. The Budget Bureau set the figure at $26 million, and at the Congressional hearings there was no indication that the figure would be increasesd.

The result, the lawmakers were told, will be "drastic constriction" in hospital operations. Complicating the situation is decision by Veterans Administration to remove about 300 of its patients from P.H.S. hospitals. Plans are to close ward areas in several hospitals, and possibly to shut down completely as many as three hospitals.

DELAY AT BETHESDA

A snafu, rather than dollar economy, is responsible for the delay in opening the $60 million, 500 bed clinical research center at Bethesda. It was to have opened in April; now the plan is to open it in July.

Here is the chronology, as related by P.H.S. officials:

1. In February the Bureau of the Budget instructed all government agencies on two points: (1) not to spend at a rate higher than their January rate of spending, and (2) not to hire new personnel.

2. In March, the F.S.A. administrator (prior to the new department) wrote the director of the budget, stating that her understanding was that the two restrictions could be ignored under the circumstances, that is, the investment involved in the Center and the necessity for hiring personnel.

3. The Budget Bureau replied: "We do not want to do that until we get some idea about how much money could be spared for 1954 so that the action for the remainder of this year would tie in to what will progress next year."

4. On April 16, while appropriation hearings were under way on Capitol Hill and after the Clinical Center delay had been disclosed, the Budget Bureau changed its mind. It authorized the Center directors to move ahead toward equipping and staffing the new institution.

The Budget Bureau delay accounted for just two months; by the time the shift in direction had been felt at the operating end, the delay was three months. Despite this, however, the expectation is that about half the Center's beds can be filled by July 1 of next year.

O.D.M. CLOSE-OUT

Preparing to close out its entire operation on July 1—a result of the abandonment of controls, not economy—is the P.H.S. Division of Civilian Health Requirements, which for more than two years has been arguing the civilian need for scarce materials.

One of the division's last responsibilities was the preparation of a special study for the Office of Defense Mobilization on the requirements of civilian hospital and health facilities during a possible period of mobilization. Considered were such factors as population migration resulting from the expansion of war industries and military establishments, need for medical care in mushrooming defense areas, the depletion of civilian population incident to increases in the military services, and the possibilities of doubling up on rooms and in other ways getting more use out of existing facilities.

O.D.M. will match this up against a similar survey of what the military services will need in a period of emergency, thereby giving a fairly accurate picture of the total requirements. The next step will be to check existing and potential facilities to determine where shortages may be expected. The survey is particularly noteworthy because it will be the first time that military and civilian health requirements have been brought into one pattern.

Another final study by the division, also for the use of O.D.M., was one in a series of surveys of equipment and supplies in the health fields to determine what the current inventory and production rates are and what may be expected in a mobilization period.

No announcement has been made, but it is likely that the remaining responsibilities of this division on July 1 will be transferred to Dr. Cronin's Division of Hospital Facilities.

INDIAN HOSPITALS

A behind-the-scenes contest is under way to determine what federal agency is to have responsibility for the health of the half million or so American Indians.

More than a year ago a group of state public health directors started a campaign to shift the responsibility, including control of Indian Service hospitals, from Department of the Interior's Indian Bureau to U.S. Public Health Service in the Department of Health, Education and Welfare. Last year P.H.S. took no official position, but informally a number of P.H.S. officials indicated they thought it was a good idea.

All that is changed now. The official position of the H.E.W. department is that the shift alone wouldn't ensure more or better medical care for the Indians. If they say anything, P.H.S. officials now stay within the policy line laid down by Secretary Hobby. At this writing, Department of the Interior has not taken an official position. However, there is almost no question as to where it will stand: it will oppose the transfer for about the same reason as P.H.S. and H.E.W.

Meanwhile, the interested state health officials continue their work with congressional committees, a futile effort as long as the Eisenhower administration doesn't ask for the change.

So much for the record. The facts, not on the record, are these: (1) The administration won't approve the shift mainly because it promises to cost a large amount of money (with P.H.S. raising the standard of Indian hospitals). (2) P.H.S. doesn't want the added responsibility because (*a*) it's afraid Congress won't appropriate enough money for the work, and (*b*) the service expects it will have trouble attracting enough physicians once the doctor draft is lifted and physicians won't be turning to P.H.S. to serve out their required two years. (3) There is some talk of a plan to shift all responsibility for Indians to H.E.W.; if such a transfer actually is being arranged, it would not be expedient to shift health functions only at this time.

NOTES

Special A.M.A. and Blue Shield committees will work together on mutual problems, but have decided not to merge into one group. However, some studies will be undertaken, including a survey of physician reaction to voluntary health insurance, and an effort will be made to arrange for more A.M.A. representation in Blue Shield.

The Office of Education's "Higher Education," Vol. IX, No. 17, is mainly devoted to a report on professional education in hospitals, prepared by Dean Conley, executive director, American College of Hospital Administrators.

For policy reasons, P.H.S. is opposing a bill to make eligible for a Hill-Burton grant a hospital in La Jara, Colo., that was started without prior approval; P.H.S. has no objection to the grant but fears a series of such bills if this one passes.

The Modern Hospital
JUNE 1953



LOOKING AROUND

Long Story

MAN named O'Rear got sick. Had operation at Union Hospital, West Frankfort, Ill. Ran up bill. Left hospital owing $150. Hard times. Couldn't pay. Left town. Moved to Alabama. Brooded about debt. Saved up. Went back to West Frankfort, Ill. Paid bill. Hospital surprised. O'Rear in arrears thirty years.

Fact Stores

EDUCATION is a word that is going to die of exhaustion if we don't stop abusing it. A beautiful word that should be handled with tender precision, it is flung about recklessly instead. Like a respectable boarding house harboring thieves, its venerability is made to conceal all manner of lesser activity, from salesmanship and press agentry to downright fakery. Even the colleges and universities, presumably devoted to education, have been abusing the word, using it to describe a process in which the student, or customer, is stuffed full of facts about a certain livelihood.

As a few educators have been pointing out right along, these processes may have their place in our society, but they have little in common with education, which is concerned with training the mind to function effectively—not simply filling it with facts, like a beanbag, and then sewing it closed. Education, for example, teaches students to read and write; they may then be trained in journalism or advertising, and probably the best place for that training is on the job. Education teaches the disciplines of economics, and a boss in a blue suit will teach the facts of banking, or insurance, or securities. Education in hospital administration, as Ray Brown suggested at one of the regional conventions this year, is concerned with basic sciences and the purpose of the hospital in our society, not with cleaning walls and counting sheets. "A broad study of industrial relations, plus an understanding of the uniqueness of the hospital, is better than a course in hospital personnel," he said.

This is not to say that walls and sheets and personnel are not important to the administrator. He must know enough about these things to judge the performance of his wall cleaners and sheet counters, but his highest responsibility is to understand the purpose of his institution in society, and to lead it toward that purpose and measure how well it is going. An education that does not prepare him for this responsibility is not an education. A convention or institute that does not concern itself with philosophy may be a useful convention or institute, but it is not education either. The college or university that capitulates and gives its students the kind of information they demand, rather than the kind of education they need, has abrogated its responsibilities as an educational institution. It may be an effective retail outlet for certain facts—of journalism or banking or hospital administration—but it does not educate. Too many of our colleges and universities have become fact stores—and the fact stores, actually, are frauds, because the student with an education can learn all the facts he needs for nothing.



Progress Report

HOSPITAL and medical people who have had high hopes for the success of the Joint Commission on Accreditation of Hospitals have been gratified by early reports of the commission's progress. Reporting to the regional hospital conventions, Dr. Edwin L. Crosby, commission director, has declared repeatedly that the commission is interested primarily in the quality of medical care offered to hospital patients. Inspections and reports have emphasized medical records, staff appointments, clinical-pathological conferences, tissue reviews, and other aspects of the medical program aimed directly at improving the quality of staff performance. Administrators at most of the 300 or so hospitals which have already been inspected have reported to their hospital friends that the inspectors, unmistakably, mean business.

At one meeting, Dr. Crosby was asked if his presentation could be interpreted as meaning that medical standards for approved hospitals could be expected to get progressively higher. His answer was an unqualified

"Yes!" and he added that in this respect the standard would be the same for comparable medical services in small and large hospitals.

Dr. Crosby and members of the commission have earned the respect and gratitude of all physicians, hospital administrators, and trustees who are genuinely interested in the welfare of patients. Already they have demonstrated the wrongness of those who felt, three years ago, that hospital standardization had to be the responsibility of a single agency, because a joint program would be too complicated to administer, and they have justified the faith of some who believed from the beginning that a cooperative program would be the most effective. The commission's performance to date is a promise that, so far as it is possible to ensure it, the medical integrity of our hospitals will keep pace with their technological development.

Reel Charity

LONG BEACH Memorial at Long Beach, L.I., is probably one of only a few hospitals that has put on a community-wide drive for fishing tackle. Located right on the ocean, the hospital has its own pier, where patients, employes and staff members may angle at will when they are not less happily occupied. Recently, Administrator William Kozma decided to invite patients from near-by veterans' hospitals to share the pier—a circumstance which made it necessary for the hospital to enlarge its inventory of spinning needles, deep sea sutures and other salt water surgical gear. Results of a community appeal for fishing gifts were encouraging, it was reported. Practically everybody can spare a rod to help a hospital.

Ten O'Clock Country

WRITING to the *Christian Science Monitor* from Kyoto, Japan, following his return there from a visit to the United States, the Honorable Gizo Takayama, mayor of Kyoto, described America recently in these immortal words: "The American people as a whole are leading the highly mechanized cultural life and yet they are not contented with the way of their living. They are unceasingly striving for the



better living. It is the mistaken criticism that America is for all-out materialistic and their spiritual culture is low. Their institutions are founded on trust of their people. The people are supporting their institutions and nobody tries to outsmart them. This must be due to their high public moral not to bring any trouble to others.

"It is not a fitted maxim that America is a country of sunset, her capitalism over-ripened. I feel that America is a young country of ten o'clock in the morning. They take their self-inventory from time to time and study it from new angles. They don't spare their trouble to be original. They are trying to see that every one on the earth enjoys his living. This is the fundamental idea of the leading people there."

Sauce

IN A BOOKLET entitled, "Winning Ways With Patients," the American Medical Association has described sensible rules of conduct for secretaries and receptionists in doctors' offices. Some of the rules and reasons might be studied with profit by admissions clerks, cashiers, nurses and others who come in contact with patients in the hospital. Examples:

"Cultivate a pleasant, calm voice and don't use slang or bad grammar in your conversation with patients. The people who visit the doctor's office are ill, usually nervous, and sometimes supersensitive to a high-pitched, nasal or loud voice. It is especially necessary to speak softly so that when you are taking down personal information, other patients cannot overhear you. If patients have trouble understanding you, don't shout, but speak more clearly and more slowly.

"The patient . . . is worried about his health. If he has to wait a long time and is made to feel unimportant, he becomes resentful. Patience, finesse and tact are needed to handle patient appointments. It is the spirit, rather than the actual date or hour, which counts most in making appointments.

"If your [telephone] voice conveys cheerfulness, interest and friendliness, it will be easy to establish cordial patient relations at once. Offer assistance by the tone of your voice and make the patient feel you have time to handle his wants, regardless of how tedious these requests may be.

"Waiting time to the caller seems interminable. Anything you can do to relieve anxiety is of great value.

"It is easy to be pleasant and helpful to the people you like. The persons who demand all your understanding and patience are the unreasonable, whining, snobbish, uncouth or stupid ones. Every irritating situation should be a challenge to your ability to handle people. Don't let the unpleasant, unreasonable patient affect your own composure. See how deftly you can manage the situation.

"Most complaints about the medical profession today are centered about fee problems. The bill is considered too high or it isn't clear. In most cases, such difficulties could be avoided by explaining medical charges in advance to patients."

"Winning Ways With Patients" is intended for office help, but it is sound doctrine for everybody involved in the care of the sick. The person who can accomplish the most good by observing these rules, as a matter of fact, is the physician himself. What's sauce for the nurse is sauce for the doctor.

Gift

ILL wind," Anastasia said, handing us a newspaper clipping.

"Wilson Gives Stock to Hospital," said the headline. The story related that Secretary of Defense Charles E. Wilson, when he was required to dispose of his General Motors stock following Senate committee hearings on his qualifications for the appointment, gave 1500 shares to Detroit's Harper Hospital for medical research.

"What do you think of that?" we asked Anastasia.

"One man's heat is another man's research," she said.

PROTOTYPE STUDY: THE 50 BED HOSPITAL

All the facts about the 50 bed hospital as it exists today—comprising a useful tool for self-evaluation and an adaptive guide to administrative planning

LOUIS BLOCK, Dr.P.H.
Program Coordinator
Division of Medical and Hospital Resources, Public Health Service

ALTHOUGH basic similarities in function do exist, each hospital is an entity in itself to a certain degree. As such, it presents variations from any guide or composite because of local situations and local differences. Despite this, application of existing guides in planning over the years has established their usefulness, and their merits have become well recognized.

Many times it has been found that a program of anticipated hospital operation is necessary properly to develop both the areas of community needs and hospital design, construction and equipment. Without knowledge of hospital operation, little real advancement could be made in either of these areas.

One must realize that written programs are based upon measurable experience and facts—and such facts are, especially in the area of hospital operation, largely obtained from statistics. Understanding of the problems accompanying the use of existing hospital statistics and data is required.

Hospital statistics may be national, regional, local or individual in scope. As one progresses from the individual to the national picture, the information obtainable moves from the specific to the general and from narrowly defined to much broader areas. Necessity has dictated such generalizations with regard to national data because of the magnitude of the job and the expense involved in obtaining specific information regarding the hospitals of the United States.

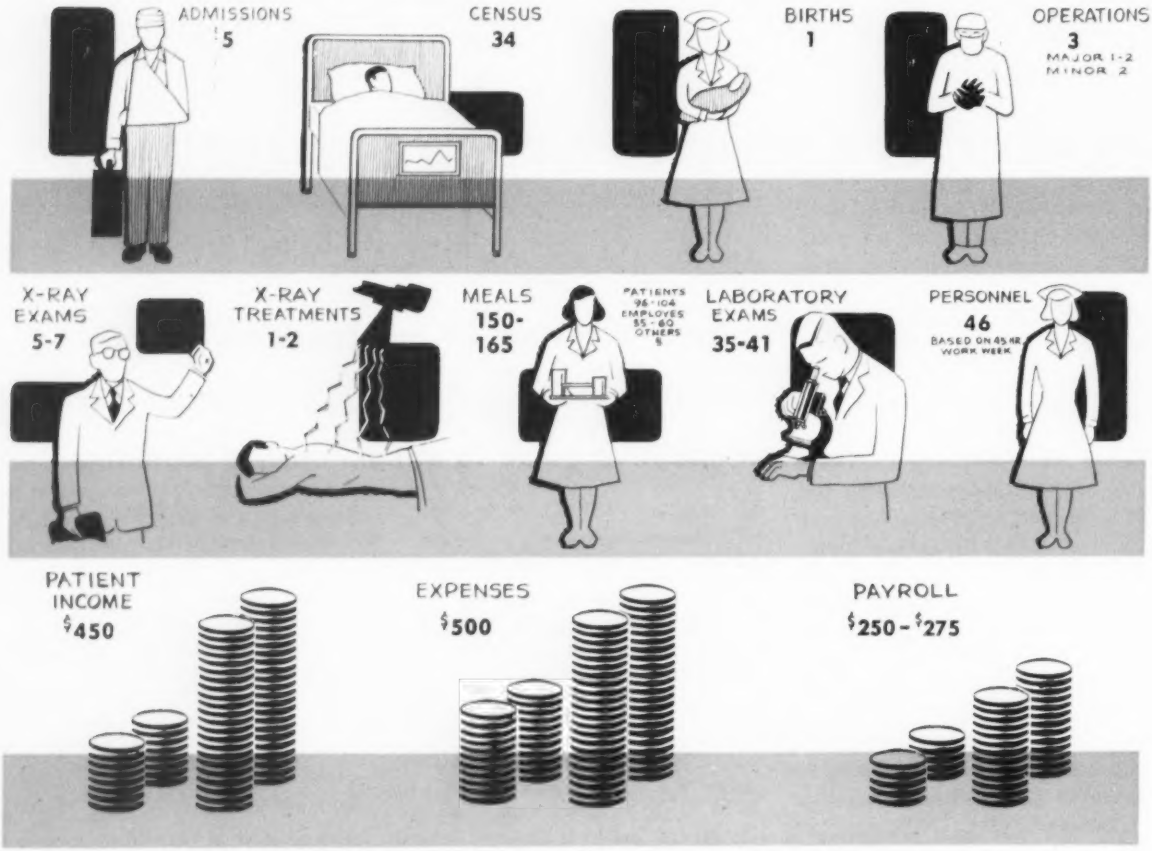
Reported information on a national basis has been limited to numbers of institutions, beds, broad utilization information, and gross personnel and financial data. There does exist a tremendous reservoir of specific and detailed information regarding hospital activities and operations in various individual hospitals, local and regional groups. We have failed to utilize this fount of knowledge for purposes of real planning because, in the language of the statistician, it has lacked representativeness, and situations in one area were unlike situations in other areas. This is true without question. Because of this, little real use is made of available information regarding circumscribed localities which might be applied to hospitals of the United States.

However statistically unsound it might appear, however strong the criticism of the approach may be, this tremendous store of hospital information must be made available for general use. Too often, when a specific question is asked, the answer is "Something was done along that line and information is available for a specific hospital or locality. If this is adapted to your situation it would prove helpful." If this latter is true, then therein lies the possibility of salvage of a vast amount of information for planning and guide purposes.

Emphasizing our original premise, that this kind of information is essential in understanding and approaching an individual problem, it is possible to apply the proportionate variations from the local averages in the area where studies were made to national, regional and state averages and come forth with guides of national, regional and state prototypes of hospital operation. By this means it is possible to disseminate helpful information to those having a direct responsibility in the planning and operation of hospitals and hospital programs.

This information concerning hospital activities is called "Prototypes of Hospital Operation." A "prototype" is generally defined as a pattern. It de-

An Average Day's Activities in the 50 Bed General Hospital Prototype



In this prototype of hospital operation for the 50 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

scribes "what is" rather than "what should be." This emphasis on the typical or average is obviously beset with many dangers if it is not properly applied. It can be an extremely useful tool for self-evaluation and as a general guide to administrative action when adapted to one's particular needs.

The following prototype is an example of applying these technics and facts to a 50 bed nonprofit, general hospital.

Functional design of a particular hospital is dependent upon many factors which include services provided, departmental relationships, and administrative processes. Regardless of the general plan of the hospital and its layout, what is most important are the activities that are performed and the services that are provided in these facilities. Many of these hospital functions revolve around bed distributions and assignments.

Table 1—Frequency of Additional Services

Patient Group	*Frequency of Occurrence*	*Average Number of Beds Assigned*
Pediatric	1 in 3 hospitals	6-7
Isolation or contagious	1 in 9 hospitals	3
Chronic	1 in 25 hospitals	7-8
Nervous and mental	1 in 50 hospitals	7-8
Tuberculosis	1 in 100 hospitals	12

BED DISTRIBUTION

Major. In more than half of these hospitals, medical, surgical and obstetrical patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. The medical service accounts for approximately 34 per cent of all beds, surgery for 40 per cent, and obstetrics for 26 per cent. This means that the average 50 bed general hospital has: 17 medical beds, 20 surgical beds, and 13 obstetrical beds. In many instances it is common practice to combine medical and surgical services. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.

Additional. In addition to the three basic groupings of patients found in more than half of these hospitals, the 50 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are con-

sidered as additional services. Table 1 indicates these additional services, frequency of their occurrence, and average number of beds assigned them.

Bassinet Distribution. The average number of bassinets for newborn is the same as for obstetrical beds, 13.

Four out of every 5 of these hospitals have infant incubators. They average 2 such units per hospital.

Only 1 in 5 has special nurseries for premature infants.

UTILIZATION

The kind, type and number of patients admitted to the 50 bed general hospital are as follows:

Admissions. An average of 1800 to 1900 patients is admitted during the year, averaging 36 to 38 admissions per bed per year.

Births. There are approximately 375 live births during the year. Of this number 20 to 25 will be premature. There will be an average of 4 sets of twins during the year, and 1 set of triplets can be expected every three years.

Deaths. There are approximately 68 deaths during the year, 47 of which are institutional (deaths occurring 48 hours or more after admission) and 21 are noninstitutional (deaths occurring within 48 hours after admission).

The gross death rate (total deaths divided by total discharges) is around 4 per cent. This means that approximately 4 out of every 100 patients discharged die in the hospital.

The net death rate (institutional deaths divided by total discharges) is around 3 per cent. This means that approximately 3 of the 4 deaths per 100 patients discharged are considered as institutional deaths.

There will be approximately 4 premature fatalities during the year.

Autopsies. An average of 5 autopsies is performed during the year.

This shows an autopsy rate of 8 per cent (autopsies divided by total deaths).

Patient Days of Care. The hospital provides around 12,410 days of care.

Of this number an average of 5840 are for medical patients, 4745 for surgical patients, and 1825 for obstetrical patients.

Newborn Infant Days of Care. In addition, approximately 2000 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 34 patients is cared for in the hospital daily.

Of this number, 15 or 16 are medical patients; 13 or 14, surgical, and 5, obstetrical patients.

An average of 5 or 6 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 64, varying from 50 per cent in private accommodations to 70 to 80 per cent in semiprivate and ward accommodations.

The percentage of occupancy approximates 80 to 90 for medical services, 60 to 70 for surgical, and 40 to 50 for obstetrical services.

Newborn occupancy approximates 40 to 45 per cent.

Average Length of Patient Stay. Length of patient stay averages 6 to 6½ days.

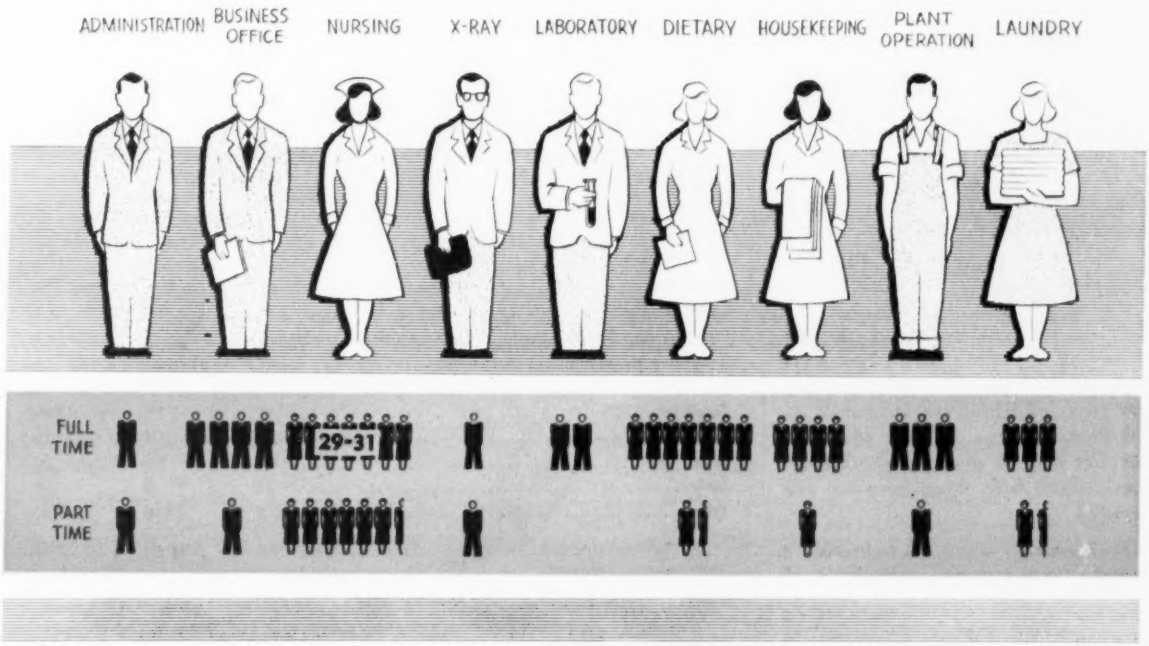
This varies by type of accommodation as follows:

Private	6 days
Semiprivate	5-6 days
Ward	8-9 days

Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford a slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

Length of stay for all patients varies by diagnosis as follows:

Average Number of Full-Time and Part-Time Paid Personnel



Medical	10-11 days
Surgical	6- 7 days
Obstetrics	4- 5 days
Pediatrics	5- 6 days
Gynecology	5- 6 days
Genitourinary	8- 9 days
Orthopedics	9-10 days
Ear, nose and throat	1- 2 days
Ophthalmology	6- 7 days
Other	5 days

More than three-fourths of all patients admitted are discharged within one week. The per cent of patients discharged according to length of stay shows:

Length of Stay	per Cent	Cumulative
1 day	20	20
2 days	10	30
3 days	10	40
4 days	12	52
5 days	11	63
6 days	8	71
7 days	6	77
8 days	3	80
9 days	3	83
10-13 days	9	92
14-20 days	4	96
21-30 days	2	98
31 days and over	2	100

PERSONNEL

Numbers. The average number of full-time paid personnel ranges from 50 to 55. The average number of part-time paid personnel ranges from 10 to 15.

This amounts to an average of 160 full-time employes per 100 patients, 1.1 employes per bed, or 1.6 per occupied bed.

SERVICES

Major. The following services are found in more than half of the existing 50 bed general hospitals:

X-ray diagnosis	9 hospitals in 10
Basal metabolism	4 hospitals in 5
Clinical laboratory	4 hospitals in 5
Electrocardiograph	3 hospitals in 4

These services together with medicine, surgery and obstetrics can be considered as major, to this hospital group.

Additional. Services that might be provided but are generally found to occur in less than 50 per cent of the facilities are considered additional. The following indicates some of these services and the frequency with which they are provided within the individual institution. Certain of these additional services may be provided through arrangements with other hospitals and sources.

X-ray therapy	1 hospital in 5
Routine x-ray on admission	1 hospital in 8
Postoperative recovery	1 hospital in 20
Outpatient	almost 1 in 2
Pharmacy	1 hospital in 3
Physical therapy	1 hospital in 5
Social service	1 hospital in 25
Occupational therapy	1 hospital in 50
Blood bank	almost 1 in 2
Central supply room	almost 1 in 2
Electroencephalograph	1 hospital in 33
Patients' library service	1 hospital in 3
Children educational program	1 hospital in 50
Medical libraries	2 hospitals in 5
Dental departments	1 hospital in 10
Cancer clinics	1 hospital in 10
Mental hygiene clinics	1 hospital in 65
Training courses, auxiliary nursing personnel	1 hospital in 12
School of nursing	1 hospital in 100

DEPARTMENTS

Dietary. An average of 55,000 to 60,000 meals is served annually; 35,000 to 38,000 are served to patients, 20,000 to 22,000 to employes, and 2000 to other persons.

About one-third of the hospitals employ a dietitian. In those hospitals that employ a dietitian, they average one such person per hospital.

Laundry. Approximately 55 per cent of these hospitals will operate their own laundry. Those that do operate a laundry average 1 employe for every 12 or 13 hospital beds. In these hospitals the laundry processes between 125,000 and 150,000 pounds or 250,000 to 300,000 pieces a year.

Hospitals operating laundries have an average water consumption of 11,835 cubic feet per bed per year; those not operating laundries average 9277 cubic feet per bed per year.

Operating and Delivery Rooms. Hospitals average 2 or 3 operating rooms. They average 1 or 2 major operating rooms. The chances of having either 1 or 2 such operating rooms is equally divided. They average 1 or 2 minor operating rooms. The chances are better for having only 1 minor operating room.

The average number of operations approximates 850 per year. Of this number 325 to 350 are major and 500 to 525 are minor.

The average number of deliveries approximates 375 to 400 per year. Of this number 12 to 15 are cesarean sections.

X-ray. An average of 800 inpatients and 775 outpatients is examined during the year in the x-ray department.

These patients are given approximately 2000 examinations, 1125 for inpatients and 875 for outpatients.

Where x-ray therapy is provided, approximately 435 treatments are given during the year, 40 to 50 for inpatients and 385 to 395 for outpatients.

Sixty per cent of the hospitals have physician staff members specializing in radiology; 13 per cent have them full time, and 47 per cent, part time.

Laboratory. Approximately 12,750 clinical laboratory examinations are performed during the year; 11,000 for inpatients and 1750 for outpatients.

The ratio of these examinations to patient days of care is 0.9 per cent of an examination per patient day, for inpatients.

The approximate breakdown of these examinations by kind of examination is shown in Table 2.

Forty-seven per cent of the hospitals have physician staff members special-

Table 2—Breakdown of Examinations

	Inpatient	Outpatient	Total
Hematology	7,175	1,175	8,350
Blood chemistry	450	150	600
Urinalysis	1,650	100	1,750
Pathology specimens	310	15	325
Pathology microscopic	265	10	275
Electrocardiograph	140	35	175
Basal metabolism	25	40	65
Serology	700	50	750
Bacteriology	50	10	60
Spinal fluid	20	10	30
Stool	15	5	20
Others	200	150	350
Total	11,000	1,750	12,750

Table 3—Value of Perquisites

Perquisite	General Staff Nurse and Clerks	Practical Nurse and Untrained Pers.
Single room	$22.00	$16.50
Double room	16.50	11.00
One meal	16.00	16.00
Two meals	31.50	26.00
Three meals	47.00	39.00
Laundry	4.50	3.50

Table 4—Policies Covering X-Ray and Laboratory Charges

Inpatients	Lab. Charges	X-Ray Charges
Same to all	23 per cent	15 per cent
Only ward different	40 per cent	47 per cent
Different to all	32 per cent	40 per cent
Flat rate to all	4 per cent	.....
Clinic Patient	**Lab. Charges**	**X-Ray Charges**
Same as ward	38 per cent	42 per cent
Different from ward	52 per cent	51 per cent
Same as private	10 per cent	7 per cent
Private ambulatory patient		
Same as private patient	95 per cent	95 per cent
Same as semiprivate	3 per cent	5 per cent
Different for all	2 per cent	.....

izing in pathology; 7 per cent have them working full time, and 40 per cent, part time.

Blood Bank. Almost 1 in 2 of these hospitals have blood banks. Those hospitals having blood banks issue 200 units of 500 cc. per year.

Their average stock amounts to 10 units.

Their blood supply is obtained as follows: 34 per cent from donors in the hospital, 2 per cent from other hospitals, 4 per cent from nonhospital sources, and 60 per cent from Red Cross centers.

Medical Records. Sixty-three per cent of the hospitals have medical record librarians; 23 per cent employ registered, and 40 per cent employ nonregistered medical record librarians. Those hospitals employing medical record librarians average one such person.

Nursing. At least one-half of the full-time nursing personnel is nonprofessional, such as practical nurses, nurse's aides and attendants.

FINANCIAL

Assets. Total assets per bed amount to $6500.

Plant assets per bed amount to $4600, or 71 per cent of total assets.

Expense. Expenses per hospital per year approximate $180,000.

Average expenses per patient day averaged a little over $15, varying from $19 to $20 for private patients, $16 to $17 for semiprivate patients, and $14 to $15 for ward patients.

Average expense per patient stay amounted to $95 to $100.

Pay Roll. Average annual pay roll amounted to $90,000 to $100,000.

Average annual salary per employe approximated $1800 to $1850.

Average starting salary per month amounted to $223 for general duty nurses, $157 for practical nurses, $122 for untrained women, $151 for untrained men, and $153 for clerks.

Pay roll amounted to 54 per cent of expenses.

Perquisites. The value of perquisites per month varied as shown in Table 3 for general duty nurses and untrained personnel:

Departmental Expense. The departmental breakdown of expense shows:

Administration	9-11 per cent
Dietary	15-16 per cent
Housekeeping	5 per cent
Laundry	3 per cent
Plant operation	7 per cent
Medical and surgical	5-6 per cent
Operating and delivery rooms	6 per cent
Pharmacy	7 per cent
Nursing	26-27 per cent
Anesthesia	2 per cent
Laboratory	5 per cent
X-ray	5-6 per cent
Other	1-3 per cent

Income. Patient income for the year approximates $160,000. Patient income per patient day averaged a little over $14, varying from $25 to $26 for private patients, $20 to $22 for semiprivate patients, and $10 to $12 for ward patients.

Average patient income per patient stay amounted to $90 to $95.

Patient income amounted to approximately 90 to 95 per cent of the expenses.

Room Charges. Generally speaking, hospital charges for room, board and routine services do not cover the cost of providing such care.

The average daily room charge amounted to $10.37 for single rooms, $8.38 for 2 person rooms, and $7.15 for multiperson rooms.

Laboratory and X-Ray Charges. The policies shown in Table 4 cover the making of x-ray and laboratory charges in hospitals.

The general practice for laboratory service is to charge private patients a higher rate than semiprivate; to charge semiprivate patients a higher rate than ward; to charge ward patients a higher rate than outpatients, and to charge private ambulatory patients a rate comparable to that for private patients.

Drugs. Eighty per cent (4 in 5) of the hospitals charge the patients for drugs carried on the nursing unit.



ASSOCIATION OF WESTERN HOSPITALS: Left to right: D. L. Braskamp, administrator, Alhambra Community Hospital, Alhambra, Calif., and Richard Highsmith, Children's Hospital of the East Bay, Oakland, Calif.; new president, Orville N. Booth, St. Francis Memorial Hospital, San Francisco, shakes hands with Dr. John W. Cline, past president of the A.M.A.; Frank Lloyd Wright and Melvin Scheflin, association executive secretary.

Western Hospitals Get the Wright Treatment

SALT LAKE CITY.—Assembled here April 27 to 30 for the 23d annual convention of the Association of Western Hospitals, 1750 hospital executives from eight western states were admonished to:

1. Decentralize and build "hospitals that smile" instead of "commercialized monstrosities."

2. Study psychology and sociology to improve their understanding of human behavior and hence their effectiveness in management.

3. Think of long-term objectives and the hospital's rôle in our society, as well as the daily administrative tasks.

4. Plan education programs for tomorrow's administrators to emphasize theoretical knowledge on which sound decisions can be based, rather than detailed hospital technics and practices.

The convention itself, as it turned out, divided its interest about evenly between theory and practice, with the general sessions having a philosophic flavor and section meetings, for 16 separate departmental groups, reporting and discussing hospital technics. The quality of both programs was apparent in an unusually low walkout index; instead of program-hopping, most people stayed in the meetings and listened. Between sessions, they ran up mileage and wordage among the 75 technical exhibits which spilled out of the Hotel Utah's ballroom and mezzanine into sample rooms.

Like a man with a hard day's work ahead of him, the convention started by taking a cold shower—administered in this case by Architect Frank Lloyd Wright, who suggested that our civilization may be about to go over the brink and added that this might be the best solution. Hospitals are generally too big and too commercialized, Mr. Wright said. Patients are treated like merchandise and piled up like cordwood, instead of being given the beautiful environment sick people need. "There is nothing as healing as beauty," he declared.

Hospitals, like civilization itself, must decentralize to recapture the individuality that is the birthright of our democratic society, Mr. Wright told the convention. "They are all too big, and getting bigger," he charged. Recommending small hospitals "that are really acquainted with gardens, grounds, greenery and life itself," Mr. Wright challenged his hearers to build "hospitals that smile" outside, not in, the city—a modern phenomenon that he abhors. As he left the convention hall, Mr. Wright was detained by photographers who wanted to take his

(*Continued on Page* 170)

SALT LAKE CITY.—D. L. Braskamp, administrator of the Alhambra Community Hospital, Alhambra, California, was named president-elect of the Association of Western Hospitals during its convention here. Mr. Braskamp will succeed Orville N. Booth, administrator of St. Francis Memorial Hospital, San Francisco, who became president during the convention. Clarence E. Wonnacott, Latter-Day Saints Hospital, Salt Lake City, was the retiring president.

Other officers elected during the convention were: First vice president, Frank Walter, Good Samaritan Hospital, Portland, Ore.; second vice president, Clyde Fox, Washoe Medical Center, Reno, Nev.; third vice president, John Dare, Virginia Mason Hospital, Seattle, and treasurer, Richard Highsmith, Children's Hospital of the East Bay, Oakland, Calif.

Glenn Howell, Hood River, Ore., was named chairman for the coming year of the active community hospital section. Mrs. Vista Dow, Bremerton, Wash., was elected vice chairman of the section and Elmo H. Lund, Logan, Utah, was elected secretary.







TRI-STATE HOSPITAL ASSEMBLY: Left to right: John Hatfield, administrator of Passavant Memorial Hospital, Chicago, and his assistant Richard Weingartner; George Cartmill of Harper Hospital, Detroit, and Merton Kniseley, St. Luke's Hospital, Milwaukee; the Blue Cross gets together: Peter Klein of Michigan, Guy Spring, Otto Walls and Edward B. Morris of Indiana, Bennett J. McCarthy, Detroit, and C. Norman Andrews of Chicago.

At Tri-State, They Learned More in the Corridors

CHICAGO.—A well known but seldom mentioned fact was given official recognition at the Tri-State Hospital Assembly here last month when Elmore Petersen of the University of Colorado told the opening session of the convention, "You will learn more in the foyers and corridors than you will in this room."

It might be argued that Mr. Petersen was wrong because he failed to include that cloistered seat of hospital learning, the smoke-filled room, but there is no denying the truth of the general proposition that the educational content of the impromptu conferences at a convention compares favorably with that of the scheduled lectures and discussions.

As a matter of fact, the 7500 hospital people who attend the Tri-State Assembly every year regard the program as a technicality anyway, and frequently abandon themselves, even in huge meetings, to free-style give and take in which only the loudest voices can be heard.

Happily for Tri-State, the loudest voices, which belong to Bob Buerki and Jim Hamilton, generally turn out to be the ones with the most to say. This year, in addition to their traditional assignment as chief hecklers for the convention, Dr. Buerki and Mr. Hamilton made scheduled appearances —Mr. Hamilton to address a luncheon meeting of hospital auxiliary members, and Dr. Buerki to warn a general session on nursing that the three-year schools should not be abandoned. "They'll be with us for a long time," he said.

At its opening session, the convention held still long enough to learn the up-to-date facts of accreditation from Dr. Edwin L. Crosby, director of the Joint Commission on Accreditation of Hospitals. Dr. Crosby announced that the commission had approved two important changes in the accreditation standards taken over from the American College of Surgeons. These were:

1. A hospital with active medical records and tissue committees may hold staff meetings quarterly instead of monthly, provided the committees are actively reviewing cases on a monthly basis and reporting to the executive committee of the staff.

2. Members of the general practice section or department of the hospital staff will be assigned to the clinical services and will be responsible to the chiefs of those services, making the department of general practice an administrative and educational rather than a clinical department.

Dr. Crosby told the assembly that the commission had conducted 284 hospital surveys during the first three months of the year. He explained the point-rating system for accrediting hospitals and emphasized repeatedly

Tri-State Confers Awards

CHICAGO.—Keys for meritorious service to the sick and injured were presented at the 23d annual banquet of the Tri-State Hospital Assembly to a nominee from each of the sponsoring states: Illinois, Indiana, Michigan and Wisconsin. The awards were presented by the chairman of the assembly, Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association. The winners were: Indiana, Robert E. Neff, superintendent of Methodist Hospital, Indianapolis; Michigan, Ronald D. Yaw, director of Blodgett Memorial Hospital, Grand Rapids; Wisconsin, Nels E. Hanshus, manager of Lutheran Hospital, Eau Claire, and Illinois, Stuart K. Hummel, formerly administrator of Silver Cross Hospital, Joliet, now administrator of Columbia Hospital, Milwaukee.

that the commission was interested first of all in the quality of medical care offered to hospital patients. In reply to a question, Dr. Crosby declared that an active tissue committee is mandatory in the approved hospital. It may not be called by that name, he explained, but the staff must provide for systematic review of preoperative and postoperative diagnoses with the pathologist.

When he wasn't selling the convention down its own corridors, Dr. Petersen, who is dean of the school of business at the University of Colorado, was unwinding administration to show what it looks like inside. Essentially, he said, the task consists of plans, decisions, communications and leadership. Plans and decisions must emerge from administrative knowledge and judgment, acquired by study and through experience, Dr. Petersen said.

Because he can't do everything himself, the administrator must delegate tasks, and so he must have an organization—of which he is the leader, responsible, in the end, for the performance of all. Satisfactory performance results from proper incentive on the part of workers, he concluded, and, he added, "Remuneration is not the principal incentive." Security, opportunity for advancement, and recognition also contribute to incentive, he said.

The task of the administrator was studied again, with a British accent, when Prof. Herman Finer of the University of Chicago addressed the annual Tri-State luncheon given by the American College of Hospital Administrators. All the problems of administration—purpose, proper use of skills, method, communications, reward—are typified in the situation of two men trying to move a stone, Professor Finer told the group. Of all the problems of administration, however, the most important is self-administration, or self-control, he said. Only when he has learned to make the best use of his own abilities can the administrator become an effective leader of the "primary people," or members of the organization with whom he has face to face contact, and, in turn, teach them to be successful leaders of their own primary groups. Professor Finer recommended the democratic conference as the best method of gathering all the information needed for administrative decisions. "However good you are, you always overlook something," he said. "Nobody can foresee all the results of a decision." Thorough discussion of the problem with all the people concerned offers the best possible insurance against omitting important factors, he said. "Look for the useful truth from wherever it may come—including your subordinates," he concluded, to the enthusiastic applause of several hundred administrators, many of whom were closed-door men who think subordinates should be listened to only when they are saying, "Yes, sir!"

In another address on the convention's opening day, Maurice J. Norby of the American Hospital Association said that hospital costs would continue to go up but warned against cost comparisons and defensive statements about hospital prices. The principal reason for advancing costs is expanding hospital service, he explained, so explanations of hospital costs usually amount to "apologies for progress in hospital care." The nature of the hospital's business is such that there will always be resistance and resentment to hospital bills, Mr. Norby said. He recommended that hospital public relations efforts should be directed toward explaining the value of the service rather than analyzing the bill. "Let's talk about quality of hospital care rather than the price," he concluded. "A continuing program of public information to bring to the American people full understanding of the intricate problems of hospital administration and full realization of the quality and value of hospital care will do more toward solidifying public opinion behind our voluntary health system than any other means of promoting this program in which we all believe."

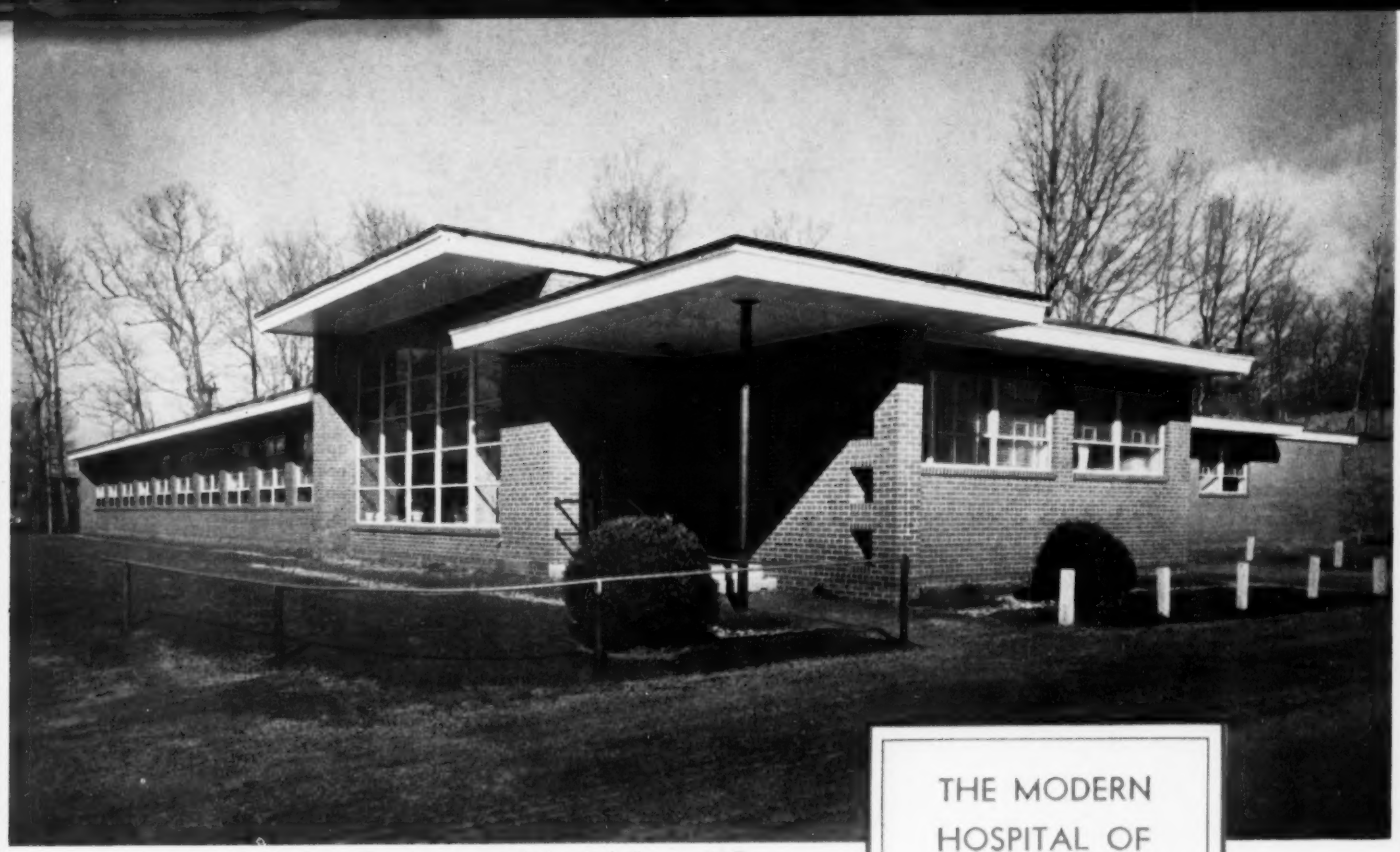
If most of Mr. Norby's hearers agreed with this view, dissent was not far away. Addressing the 52d annual convention of the Health and Accident Underwriters' Conference at another near-by hotel at the same time, James E. Powell, vice president of the Provident Life and Accident Insurance Company, warned that the increasing cost of hospital care is the biggest problem facing accident and health insurance companies today. "Hospital costs have gone up 1 per cent a month for 10 years, and they continue to mount," Mr. Powell declared. "If we can't stabilize the cost of hospital confinement, sooner or later people are not going to feel able to include hospital insurance in their budgets. So they'll turn around and ask the government to do it—and they'll pay more for it in the hidden costs."

Back among the hospital people, there was at least one who agreed that the lid should be dropped on hospital costs and thought this was possible. Speaking at a session of hospital trustees and staff officers, Dr. Josiah J. Moore, Chicago pathologist who is treasurer of the American Medical Association, declared, "The cost of medical care can be reduced when we all open our eyes and work a little more closely together." As an example of wasteful practice contributing to the high cost of medical care, Dr. Moore pointed out that hospitals located across the street from each other commonly have completely equipped and staffed laboratories, neither of which has enough work to keep busy all the time. The expense of operating these and other facilities could be reduced by centralizing and sharing services, he pointed out. Furthermore, he said, the hospital patient today is

(*Continued on Page* 166)



The Tri-State registration desk on the morning of the opening meeting. Attendance figures totaled around 7500 persons, all of whom, apparently, were in the hall on Monday.



Exterior view of Alleghany County Memorial Hospital, Sparta, N.C.

THE MODERN HOSPITAL OF THE MONTH

Low Budget Dictated High Standards

Sparta's hospital proves that quality materials cost less than replacements over the years

F. CARTER WILLIAMS
Architect, Roanoke Rapids, N.C.

THE town of Sparta in Alleghany County, North Carolina, is appropriately named. The people are rugged, determined and sincere in their efforts toward a better life. When the small but successful Alleghany County Memorial Hospital was built economy was a necessity, but that did not necessarily mean cheap materials or design. Quality materials were used in areas where severe use demanded them. Equipment was of high standard because replacement in a short time indicates uneconomical planning.

The plan is roughly a U-shape with nursing rooms to the south looking across the valley to a beautiful view of the Blue Ridge Mountains. The west wing contains kitchen and service areas and the east wing contains operating and laboratory elements with patient and personnel entrance on the east. Alternate bids were taken on a basement or first floor boiler room and a basement located under the service wing proved more economical.

The site on the side of a mountain presented a structural problem that was solved by cutting a shelf and packing a fill to the south with the hospital set on an integrated rimmed and rein-

COST DATA

Total cost, including equipment	$160,000.00
Cost per square foot	11.45
Cost per cubic foot	1.15
Number of square feet	10,872
Square feet per bed	543
Number of beds	20



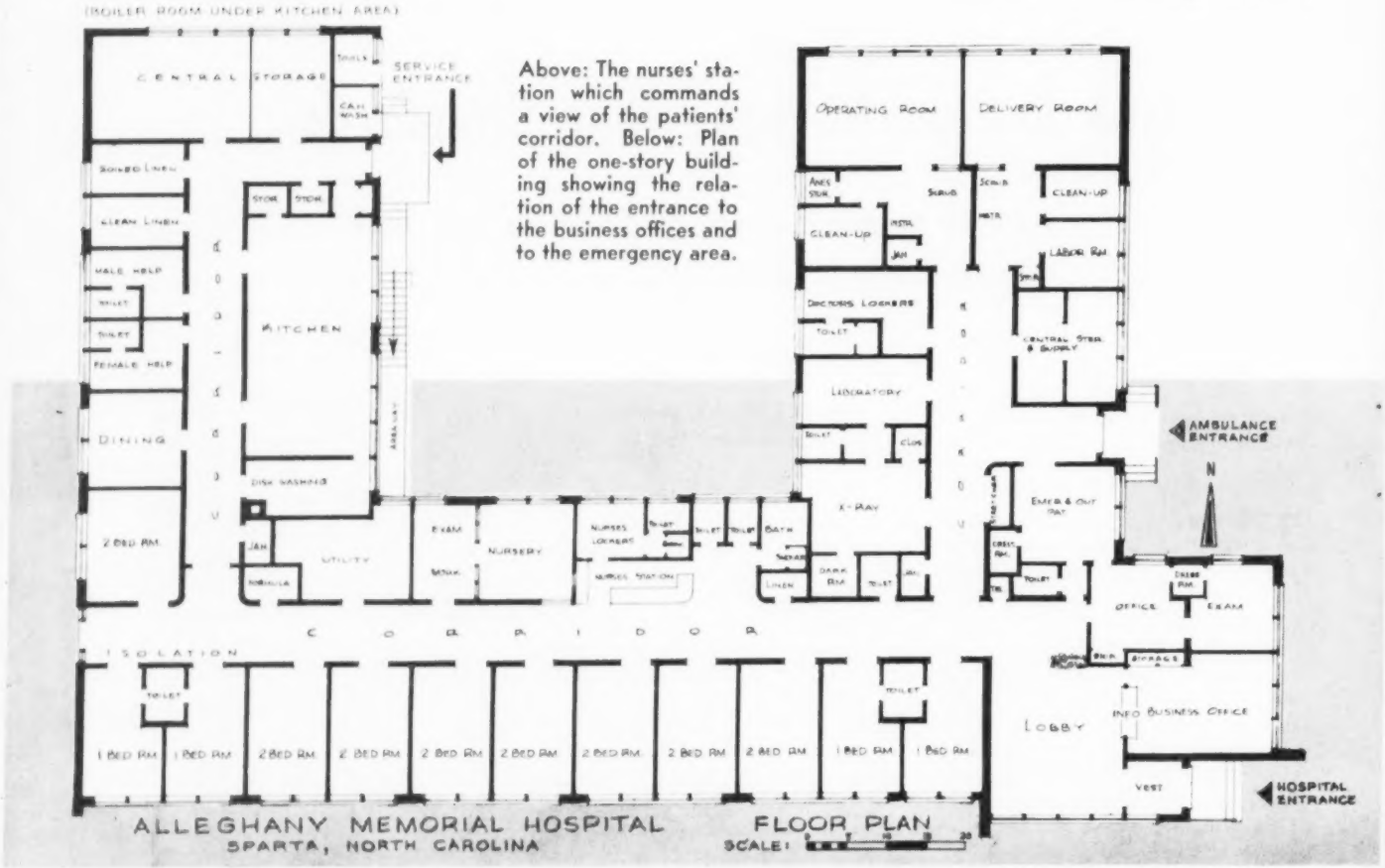
forced concrete mat anchored to the mountain. Radiant heat in the floor is satisfactory in this area where winters can be rather severe.

The functional aspects of a small hospital which provides complete services invariably produce controversy as to limitation, especially since they frequently operate at a financial loss. It is believed that this hospital has so far proved itself satisfactory in its services for emergency, obstetrical, convalescent and general needs in an area at considerable distance from any other hospital.

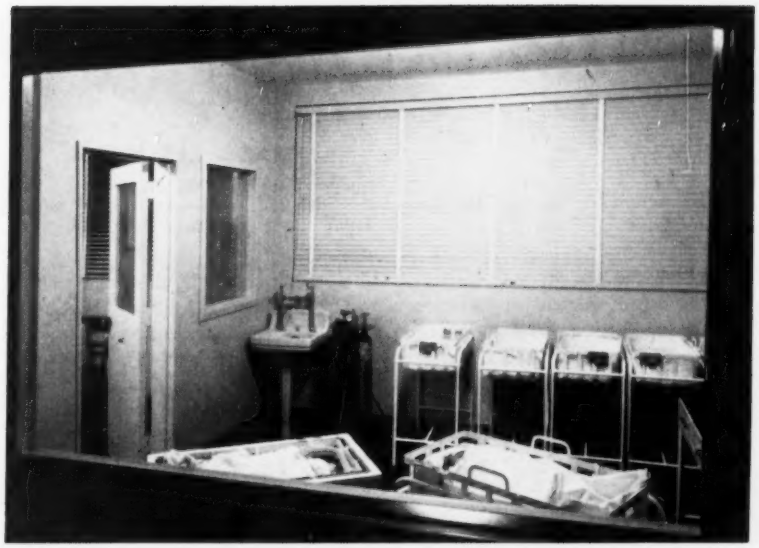
Entrance and Control. The business office and waiting room with surgeon's offices are located at the strategic area where control of patients, routine and emergency, as well as visitors, can be easily handled and supervised. A new paved road was built leading up the mountainside several hundred yards from a main highway, and ample paved parking areas are conveniently provided adjacent to the entrance.

Operating, Delivery and Adjunct Services. The operating and delivery facilities are properly separated, but all essentials for sterilizing, laboratory

Above: The nurses' station which commands a view of the patients' corridor. Below: Plan of the one-story building showing the relation of the entrance to the business offices and to the emergency area.



Top: The nursery is designed with separate examining and workroom. Center: Surfaces in the kitchen are easy to maintain. Bottom: The operating room and its adjunct facilities are located in a separate wing.







and x-ray are provided convenient to the working areas, including the emergency room.

Facing tile and ceramic tile floors were used in the operating and delivery suites. Ceramic tile floors and wainscot were used in toilet and shower rooms. Asphalt tile flooring on the concrete slab was used in other areas.

Electrical equipment was used in the sterilizing rooms. Cabinets were built-in during construction, with the customary provisions for sanitary upkeep.

Nursing. The nurses' station is located as near the center of the area as possible and so designed that the nursery, the patients and the visitors can all be supervised by one nurse on duty. Locating the patients' rooms on the south side made possible a wonderful view and bright, cheerful rooms. The use of different colors further enhances the cheerful effect, and considerable favorable comment has resulted from the color scheme.

Kitchen and Service. Tile floors and facing tile wainscot provide easy-to-maintain surfaces in this important area. Electric equipment and carefully located cabinet and other service items facilitate the efficient operation of the kitchen and storage elements.

Adequate provision has been made for handling the many items of supplies, food, garbage and waste and separate entrance facilities are located in this area which has its own paved service court shielded from the public and the patients.

Exterior and Construction. The brick exterior with overhanging protective eaves, grouped metal windows, and simple expression of the elements of the plan rests well on the side of the mountain. The severity of its treatment is appropriate to the economy of the structure and is not incompatible with the surroundings.

Steel junior beam framing with steel decking and permanent insulated roof was an inexpensive but adequate method of construction. Concrete block partitions and backing for the exterior brick walls complete the simple material requirements with the concrete mat floor on grade or fill.

Lest They Forget—Write It Down!

MARGARET HILL

Manager, Inter-Plan Bank and Transfer Division
Blue Cross Commission of the American Hospital Association, Chicago

HEADS she gets it; tails we forget it." Are the needs of today's hospital patients cared for by chance? My own recent surgical experience has me convinced that most nurses carry a coin with tails on both sides. Nursing skills mean little to a patient if the nurse cannot remember orders. My surgeon left a standing order for pain medication to be administered on request. Two hours after a local anesthetic had worn off, I asked for some. An hour later, the patient in the other bed asked if I had received my medicine, then told me that I must never wait longer than 15 minutes for something—if I had not received it by then, the nurse had forgotten about it and the request must be repeated. I pushed the signal button again. On the second trip the nurse remembered to get the medicine.

The same asking and waiting and repeating requests two or three times occurred throughout my five-day stay in the hospital. In talking to others who have been hospitalized, and to hospital people themselves, I have learned that my experience was one that is common today.

During my convalescence at home, I couldn't help thinking about the waste of womanpower and the cost of shoe leather for employes who answered patients' lights, then couldn't remember what it was they were to do for the patients. How can there be a "shortage of personnel" when there is such a waste of time and energy?

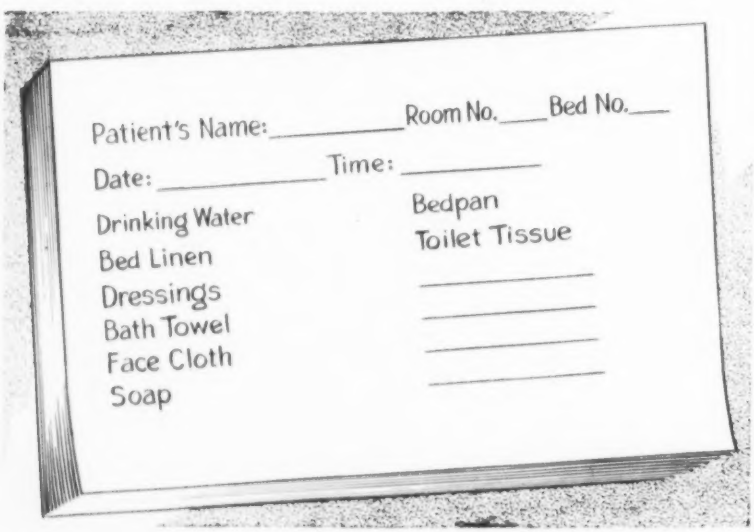
Many of us have used office memo pads with the legend, "Don't Say It—Write It." Why couldn't this principle be applied to routine nursing duties in hospitals? If the nurses had small pads of paper preprinted with spaces for the patient's name and room number and some of the most frequently requested items, and blank lines for special requests, these slips could be quickly collected by the nurse or aide answering the patient's light and turned in at the nurses' station.

If the item were one that an aide could care for, such as a glass of water, the bedpan or some other errand, the slip might be placed in a box or on a spindle for the aide to pick up and fill the order as soon as she returned to the nursing station. If the request was for a medication that required the supervisor's direction, the order would be placed in another designated spot, for the supervisor's attention. Pads of these order slips might be placed in each patient's room; if the patient were able to do so, the slip could be filled in by the patient at the time the light was turned on, and the nurse or aide answering the light could be out of the room in 10 seconds.

The temperature nurse in the morning, for example, makes her rounds, popping thermometers into mouths at great speed; when the last one has been popped, she retraces her steps, collecting the thermometers and recording the readings. This nurse could pick up request slips from every patient on the same trip. I had to learn the hard way not to ask the temperature nurse for medicine or dressings: Her job was to record temperatures, and she had no interest in any extraneous requests! Naively, I was convinced I was "helping" by asking the nurse who was already there instead of putting on my light and having another nurse come to my room. Had I had a check list, I could have filled in my name and room number and noted that I needed water, dressings and some empirin tablets. Why couldn't I have checked my simple needs and handed the slip to the nurse on her routine trip to the bedside, saving her a round trip?

Pads for the nurses could be made up in a size small enough to fit in the uniform pocket, with perhaps 10 or 20 sheets to a pad so as not to add bulk. Pads for patients might be a larger size to facilitate writing and to distinguish between requests filed by the nurse and those completed by the patient. The general hospital might use a slip something like the one shown in the accompanying drawing.

Some hospitals might want to retain the slips for spot checking on service. If such surveys were desirable, the time of completion of requested service and the initials of nurse or aide could be indicated. On days of high census, the waiting time on service might be a guide to reassignment of duties among student nurses or aides, or the need for additional personnel for a particular floor or wing.





The Administrator Goes to Surgery

with benefit to the patient, the surgeon, and himself

SAMUEL W. FRIEDMAN, D.D.S.

Administrator, Southern Division,
Albert Einstein Medical Center,
Philadelphia

THE impulse of the surgeon to be severely critical of the administrator is due in large measure to his lack of knowledge of the circumstances which compel an executive to harp on budget statistics and controls while showing a glass eye toward expenditures of money for space, equipment and facilities generally. He, the administrator, is, in the opinion of many surgeons, responsible for the defective suture material that tore at a crucial moment, for the old suction apparatus that refused to function the other day, for the excessive humidity in the operating room, for the cheap soap at the scrub sink, which irritates the skin, and, in particular, for the seeming negligent and monotonous refusals to authorize new equipment and better tools.

HE SILENTLY STEALS AWAY

For these reasons it sometimes happens that, when a hospital administrator finds himself in the exposed position of requiring a surgical operation, he wisely packs his toothbrush and last month's financial report, adopts an alias, and has himself admitted to a hospital far away from his own. Sanctuary from his surgical inquisitor he may have found, but what kind of suture material does his brother administrator buy? Are the outlets in that operating room explosion-proof, are the floors conductive, is the apparatus grounded, do the autoclaves work, will he fall out of bed, develop an incision abscess, come out of it alive or die on the operating table?

The smart administrator will, therefore, do well to exchange his business suit for a cotton scrub-suit and, in mask cap and gown, inspect the activities in his own operating suite to detect any possible evidence of his personal administrative negligence.

This he proceeds to do. The locker room where he changes his clothing is well furnished and equipped with lounge, chairs, tables, telephone, dictating machine, showers, toilets, wash basins, ash trays, magazine racks, and a row of lockers. The air is close and humid. It's a hot day. Two men are doubling up in one locker. During a busy operating schedule, there is a shortage of lockers. Complaints have been registered to him about these conditions. How much will it cost to extend the air conditioning into this room? Can the job be done with the hospital crew, or must it be let to an outside contractor? Is it worth it, is it desirable, is it necessary? Soon the summer will be over. Why spend the money? If more lockers must be provided, it will mean an additional expenditure. There is not much room for them anyway, he argues. They will only crowd the place and disrupt the furniture arrangement.

What is more important, and here he has found something, is that rack of shoes belonging to the visiting surgeons. Out of 20 pairs, six are not conductive. This is bad, very bad! The names of the owners are jotted down. They will have to be spoken to, and the operating room supervisor must be instructed to tighten up on the regulations. Fretting and fussing, the administrator steps out into the corridor and almost collides with a stretcher that is being wheeled in and on which is strapped a patient in deep sedation.

Justifying his curiosity, the administrator thumbs through the patient's chart. It reveals an admitting diagnosis of inactive rheumatic heart disease, with pure mitral stenosis and symptoms secondary to pulmonary hypertension. A man of 47, the patient has been bedridden for almost a year with a history of coughing up blood, increasing dyspnea, and signs of congestive failure. The operative procedure recommended is a mitral commissurotomy in which the skilled surgeon introduces his finger into the heart and tears apart the scar tissue in the mitral valve.

HE HAS SO MUCH TO DO

With a sudden glow of nostalgia for his comfortably nonaseptic office, the administrator reminds himself that this would be an excellent time to go back to it and review that DC-AC change-over for the dormitory building, to go over the financial implications of a pay cafeteria, to determine the traumatic result to his budget of an across-the-board raise for nursing personnel, and to make a hotel reservation for the forthcoming hospital convention. Let the surgeons probe with their fingers and administrators

Dr. Friedman was formerly assistant director of Montefiore Hospital, New York City.

fight with their boards! Each man to his own last.

But, what if the administrator were the patient? What if this procedure were to be done on the administrator's heart? In that event, it must be realized that departmental activities, and the professional services of a hospital, require administrative coordination and control and are, in the final analysis, necessary for the full cure of the patient. This very patient, then, about to undergo a most hazardous operation, represents the ultimate trial of the hospital's services and efforts from the exalted administrator down to the lowly porter. The quality of his care, up to this point, is more acutely indicative of the caliber of the hospital as a living institution than jaundiced accounting reports and frigid statistics.

Morally bolstered, and with elevated blood pressure, the administrator decides to see, by means of a further examination of the chart, how well the patient has been prepared for his dangerous adventure in the operating room.

EVERYTHING IS READY

The patient, it is seen, was admitted seven days earlier for a complete workup, which included a history, physical examination, blood count, urinalysis, EKG, venous pressure, circulation time, blood grouping, chest and special oblique heart x-rays, and a cardiac catheterization. His congestive failure was controlled by digitalis and mercurial diuretics, and he was put on a salt poor diet. His case was brought before a conference attended by the cardiologist, cardiovascular surgeon, and the cardiac-physiology group at which a mitral commissurotomy was recommended and unanimously approved. For the operation, 2000 cc. of blood was earmarked to be held in readiness. The operative permit has been signed and is attached to the chart, as are all laboratory reports and x-ray films. The time and number of cc. of urine last voided has been entered. The operative area was completely prepared the preceding night and the patient checked for false teeth, pins and jewelry. He was visited by the surgeon and anesthesiologist the day before and their comments recorded. Preoperative medication of intravenous seconal was administered to the patient before his transfer to the operating room, the administrator finds.

For his trip on the stretcher the patient has been dressed in a cotton gown, cotton leggings, cotton turban, and wrapped in cotton blankets. He has been wheeled into the operating room one-half hour before incision time. The patient is now in the waiting alcove, and from there will proceed into the induction room, where he will be anesthetized first with nitrous oxide and then carried through the operation under ether. All procedures have been, and are being, discharged to the administrator's satisfaction. Nothing has been overlooked. Nothing has been missed. This is the way to run a hospital service! The administrator sighs euphorically and decides that he may ask his board for an increase in salary.

The assembled personnel greets the administrator's entry into the operating room with polite surprise. The surgeon looks puzzled and perhaps manifests symptoms of slight irritability. Is this to be a surgical audit on the hoof? Is the administrator here to do a time-and-motion study of cardiac surgery? Does he question the professional qualifications of any of the personnel? Is he worried that too many sponges will be used? What is this administrative bull doing in a surgical china shop? He is welcome here, of course, but only horizontally, not vertically.

Radiating charm like a pot-bellied stove, the administrator, by a grunt here and a nod there, attempts to dispel all doubts and suspicions on the part of the surgical team. His heart, behind his scrub-suit, beats with noble zeal. He is here to help the surgeon, to see that he has the proper atmosphere, tools, equipment, materials and personnel, so that he can do his work efficiently, securely and comfortably. His concern is to make sure that everything possible that the hospital affords (or perhaps cannot afford) is utilized for the benefit and safety of the patient. Incidentally, the doctor benefits in the process—lest we forget!

Are the valves in the outlets for the piped-in nitrous oxide and oxygen gases of different diameter so that the wrong gas cannot pass through the anesthesia machine? (Rather late in the day to consider this!) Are the lights supplied from more than one electrical source so that in the event of power failure the surgeon will not be left in literal as well as figurative darkness? Do the gauges on the suction apparatus show sufficient pressure, and have they been checked recently by the maintenance man? Does the air conditioning maintain satisfactory temperature and humidity levels? Are bad odors dissipated?

Does the supply of sterile materials meet the needs of the operating rooms? Are the rooms soundproofed and quiet? Are all movable pieces of equipment grounded with hanging chains? Are the operating tables comfortable for the patients? Are schedules adhered to? Are operations ever canceled after the patient has been brought into the operating rooms? Are operations ever delayed over the week end without regard to clinical urgency? Are all precautions taken to prevent the explosion of anesthesia gases?

Is there a sufficient staff of professional and nonprofessional personnel to carry the work load properly and efficiently? If patient care is to be maintained at high standards, mutual responsibilities must be recognized and closer liaison must be established with the surgeon on his own ground. If the administrator is to serve the surgeon, he must see him at work so that his needs can be evaluated intelligently.

HERE COMES THE PATIENT

These musings on the part of the administrator dissipate as the attention of all personnel becomes focused on the patient who is now being wheeled in, the anesthesiologist hovering over him to make sure that the intratracheal tube is secure and the anesthetic apparatus is functioning satisfactorily.

All is in readiness. The team of surgeons, consisting of the chief, an associate and two assistants, is scrubbed, gowned and gloved. The blood monitor is at his scales and transfusion apparatus. The EKG and pressure monitors have set up their intricate equipment. Both scrub nurse and circulating nurse are awaiting orders. The patient is transferred to the table by two attendants, placed in a right lateral recumbent position, the left arm bent above the head and fixed to an ether screen. The operative field is prepared with soap and water, ether and tincture of zephiran and then draped. All personnel take their posts and a dramatic stillness envelopes the operating room. *Noli loqui! Noli tangere!* The time is 1:40 p.m.

Incision is made by the associate surgeon at 1:41 in stages through skin, subcutaneous, muscle and intercostal tissues. Bleeding points are clamped and tied off in each tissue layer before the surgeon proceeds to the next, resulting in negligible blood loss and a dry field. Speed, coordination and absence of lost motion are strikingly apparent, the scrub nurse supplying all three operators the required instruments with the most prodigious virtuosity. (Note: It is not always so!)

By 2:10, entry has been effected into the chest cavity. A lung biopsy is taken and is completed by 2:14. The chief surgeon relieves his associate at 2:21 and incises the pericardium. Four minutes later, work is called to a halt when the EKG monitor reports trouble. The patient is in arrhythmia. The lungs are oxygenated, the patient is leveled off and at 2:37, with the coordinated approval by monitor and anesthesiologist and after a hiatus of 12 minutes during which life has hung in tenuous balance, a purse-string suture is tied to the base of the auricular appendage. The apparatus for prevalvulotomy pressures is checked, the needle is introduced into the pulmonary artery at 2:46, into the auricle at 2:48, and data are posted. Four minutes later, the auricle is clamped and at 2:56 the auricular appendage is cut.

SURGEON MASSAGES HEART

At 2:59 the surgeon introduces his index finger into the heart for the most breathless procedure of the entire operation. Digital manipulation of the mitral valve is performed for a seemingly interminable period of time. The finger is finally withdrawn and, with split-second coordination, the suture is secured. The time is 3:01.

Three minutes later, a biopsy of the auricular appendage is taken. Apparatus is again checked for post-valvulotomy pressures, the needle is inserted into the pulmonary artery at 3:14 and into the auricle at 3:15, and data are posted. Closure of the pericardium is completed at 3:20. The associate relieves his chief and effects complete closure at 4:20. The patient is transferred to the recovery room 10 minutes later. Only 350 cc. of blood is transfused.

(This has been the 16th consecutive mitral cardiac operation performed without a fatality. It is an impressive record, though not a surprising one. It is the result of extraordinarily detailed and minute surgical planning in which the procedures are gone over step by step, each member of each team is briefed and rebriefed, all preparations are checked and double-checked. It is a record that could only have been achieved as a result of the research facilities and training programs that modern hospitals afford.)

Dazed but still vertical, the administrator plods after the bed in which the patient is safely tucked and sent on the way to the recovery room. Observation of the surgical field, he reflects, was not too satisfactory and straining had been uncomfortable. Perhaps it had been a mistake not to have constructed observation galleries. A movable high observation stand with seats close to the operating table might have lessened a good deal of the discomfort. However, these things cost money and it is questionable if the surgical field could be fully observed in this way. If the surgeon were to request one now, he might get it without a struggle. Like that of the patient, the resistance of the administrator is at low ebb.

It is fortunate that the patient does not have to be carted through drafty corridors and elevators at this moment before reaching his bed, the administrator realizes. The patient's chances of coming through are multiplied by the close proximity of the recovery room to the operating table. Here, in an air-conditioned unit equipped with piped-in oxygen and built-in suction apparatus and under the constant surveillance of specially trained nursing personnel, the results of the surgeon's skills are guarded around the clock. Here, nursing care is at its best, with all the necessary instruments, supplies and equipment immediately available. The construction of this recovery unit had cost a pretty penny, but the post-operative mortality rate had taken a decided drop the day it was put in operation. Speak of good investments —if this one helps to pull the patient through, its worth will be beyond price!

The administrative inspection has brought to light a number of minor lapses, resulting chiefly from interpersonal irritations and misunderstandings that normally prevail under operating room tensions. Although all physical facilities have been found to be functioning to perfection, stricter controls will be inaugurated for frequent surveillance of air-conditioning apparatus, pressure gauges of the nitrous oxide and oxygen supply, fire apparatus, utilization of conductive shoes and other maintenance problems. Beds in the recovery room will be supplied with rubber bumpers to eliminate damage to the walls. Additional fire extinguishers will be installed in certain localities, and all exit doors tested for easy operation. The blood bank, situated in a distant section of the hospital, will be moved in its entirety to a vacant area within the operating suite.

Nursing personnel will be instructed to shake all linens thoroughly so as to recover instruments, needles, syringes and other paraphernalia that might otherwise be lost and carried to the laundry, with resulting accident hazards to the laundry workers. More satisfactory arrangements will be made with the department of nutrition for ample supply of drinks and refreshments to all operating personnel. Personal complaints from surgeons, nurses and attendants will now be noted for evaluation and further definitive action.

HE SHOULD COME OFTENER

The surgeons' reaction to an administrative inspection of their domain has been favorable. Remarks like: "You should visit us oftener," "We do creditable work and the administration ought to be more successful in getting things done for us," and "If a man feels secure professionally, he will welcome the administrator's interest and attention."

Comments like these have come in profusion. Standing invitations have been extended to attend ward rounds, clinical-pathology conferences, as well as necropsies, laboratory procedures, and research experimental work. A schedule has been drawn up for the administrative personnel which encompasses weekly attendance at all the professional services of the hospital. Each will learn to understand the other's problems more intelligently, resulting in minimizing unnecessary frictions.

Although a Rotary Club atmosphere of brotherhood does not prevail at all times, the medical staff is at least assured a sympathetic hearing of its requests by the administration; feelings of hostility and distrust are relieved, and the patient's treatment and recovery are restored as the sole objective to which all resources of the hospital are equally devoted.

St. John's recruits

Nurses From Abroad

MELVIN DUNN
Director, St. John's Episcopal Hospital
Church Charity Foundation
Brooklyn, N. Y.



Class demonstration in the operating room.

FOR the last 10 years hospitals have been unable to attract enough graduate nurses to meet the ever-increasing demand. In an effort to fill this vacuum, St. John's Episcopal Hospital, Brooklyn, N. Y., has devised a plan to accelerate the circulation of the graduate nurses available to the free world. By directly approaching foreign medical institutions and offering a work-study program as student-nurse-technician to their nursing school graduates we have had some success in alleviating the nurse shortage.

This approach offers the foreign nursing school graduate a two-year resident course of instruction and practice in specialized nursing areas on a rotation plan.

AIR MAIL SPEEDS PROCESS

When we receive an answer to our solicitation, the interested nurse is air-mailed an application blank to be filled out in her own handwriting, stating her ability to read, write, speak and understand the English language. This application blank also requests data on the nurse's education, experience and other relevant matters. The age requirements are from 21 to 35 years old.

Within 10 days to two weeks (all correspondence is air-mailed) the application blank, properly filled in by the applicant, should be on hand at our hospital. Here our nursing school department thoroughly examines the qualifications as stated, paying particular attention to the requirement that the foreign applicant has graduated from a nursing school and is registered in her (or his) own country.

When and if the application is approved by our nursing school department, a special letter of acceptance from the director of the hospital is air-mailed to the applicant. This letter of acceptance includes the applicant's Exchange Visitors Program number, as authorized by the Educational Exchange Service, Department of State.

The director's letter of acceptance to the prospective guest nurse also advises her that free room and board will be provided in addition to a stipend during the two-year period of service. The guest nurse should also be advised by this time of the program of instruction and practice we will offer her and of other particulars and details of the mutually contracted obligation. We allow a period of from six to eight weeks after our letter of acceptance has been air-mailed to the applicant for her to present herself to the director of nursing at our hospital in New York City.

Each guest nurse will be given an opportunity to attend classroom instruction in principles of medicine, medical nursing, clinical instruction, pharmacology, diet therapy, communicable diseases, principles of surgery, surgical nursing, principles of obstetrics, practical obstetrical nursing, principles of pediatrics, and pediatric nursing.

Clinical experience offered will include orientation, medical clinics, diet kitchen, medicine, operating room, recovery room, surgical clinics, emergency clinic and surgery, obstetrical clinic, and advanced experience.

We have accepted 18 female and two male nurses since the inauguration of this program. Some of the guest nurses are already participating in this program, and we are well pleased with them. By early summer we expect to have a pool of 20 or more guest nurses rotating through our services. Some of the countries already represented are: Bolivia, Cuba, Chile, Ecuador, France, Germany, Italy, Lebanon, Nicaragua, Philippine Islands, Saudi-Arabia, Switzerland and Syria.

It is our aim to give the guest nurse additional instruction and experience which will broaden her professional qualifications and which will enable her to return to her own country well versed and practiced in the methods, ideas and ideals of American hospital practice. We are also prepared to receive suggestions and new ideas from these guest nurses, recruited as they are from such diverse environments, and to observe closely their richly varied talents and cultures.

APPROACH IS FLEXIBLE

The Church Charity Foundation does not deny that charity should begin at home. We are a practical people who have no intention of ignoring the needs of our own people here at home in order to render a possibly more spectacular service abroad. We have not forgotten, for instance, when many of our own people had great difficulty in finding employment. For this reason we have kept this plan flexible and intend to keep it on a time-staggered schedule so that if and when there develops a surplus of our own American medical personnel, we can let this program expire and gradually restaff our hospital and other services with American personnel. However, we can see no prospect of any such surplus developing in the near future; in fact, all indications seem to point to an intensification of our personnel shortages rather than to their alleviation.

Hospital costs are going higher, so we must make certain that ability to pay keeps pace as we plan to

Pay Tomorrow's Bills Today

HARRY BECKER
Associate Director
Commission on Financing Hospital Care
Chicago

COSTS of hospital care are still moving higher. Preliminary figures for 1952 show essentially the same upward trend as the figures for 1951 at about the same rate in most parts of the country, with the expected variation between regions. There is little hope that the costs of hospital care will not continue to rise—at least for the next few years—even should the cost of living decline.

A decrease in cost of living would not appreciably affect the daily cost of operating our nation's hospitals, because rising hospital costs are not a matter of inflation only. They also reflect underlying changes in the social and economic environment in which the hospital operates.

The long-range answer to rising hospital costs is not to be found through more efficient administration of laundry and kitchen. Economy in operation is important; it is being achieved. During the last 10 years the overhead, or housekeeping, cost of hospitals has probably been declining as a per cent of total expenditures. This decline is frequently due to increased productivity—productivity made possible, in hospitals and industry alike, by more efficient methods of doing things.

The cost of hospital care is related more to services to patients than to housekeeping. The larger volume and better quality of diagnostic and treatment services are driving hospital costs higher. Advances in medical technology in the past several decades have been as great as those in industrial technology. The hospital administrator and his staff face the never ending problem of closing the gap between existing services and new medical developments.

The widespread obsolescence of the physical plants of hospitals requires continued large outlays for the construction of new buildings designed for modern hospital care. Almost every community has hospitals that need rebuilding, in whole or in part. The wide range and high level of skills now required to provide modern hospital services is another factor in rising costs. The hospital administrator must constantly seek better qualified employes. To solve the shortage of well trained personnel for all types of hospital services requires, among other things, higher salaries and consequently higher pay rolls in many of the nation's hospitals.

The more adequate financing of hospitals in the last five years, largely as a result of prepayment programs, has helped remove the economic barrier previously retarding the development of services. The hospital of today tends to be a nonprofit community agency whose income depends primarily on earned revenues, not charity. Voluntary prepayment has grown in importance as philanthropy has decreased in importance.

Some will argue that the hospital benefits available to the population in prepayment plans are not as comprehensive and inclusive as desirable. Others point out that the monthly costs of prepayment are tending upward, thus making protection less available to some and pricing it out of reach of low income families, retired persons, and others in like circumstances.

When we examine the inadequacy of the voluntary prepayment plans—whether in terms of benefit standards, coverage, financial arrangements, or administrative organization—we must keep in mind their rate of development in the last decade. This is not to rationalize the shortcomings of voluntary prepayment. Rather, it is to give strength and validity to our planning for tomorrow.

If we make as much progress in the next 10 years as in the last 10, with the added advantages of past experience plus today's momentum, we can expect the entire employed population and its dependents, rural workers and self-employed included, to have prepaid hospital protection at benefit levels at least as inclusive as the best now available. The basis for this expectation is the projection of coverage and benefit trends of the last five years. But continuation of these trends depends on the wholehearted support of prepayment by hospitals and communities.

Today the issue is not whether we will have prepayment. Rather, the issues are: How do we finance prepayment for the low income groups, the retired, the disabled, and the un-

Condensed from a paper given before the New England Hospital Assembly in March.

employed? How are we going to reach the low income groups, the rural and self-employed workers? How fast can we raise benefit standards to permit payment for inclusive hospital services and to assure families that when illness strikes the cost of hospital care will not be an economic barrier to them or their physician?

It is not unreasonable to expect that the rate of growth of prepayment in America will continue and that improvement in benefits will more nearly cover the cost of all short, as well as all long, hospital stays. Analysis of the prepayment plans which have shown the most rapid rate of progress during the past few years in reducing the proportion of the population without prepaid hospital care supports this prediction.

Contrary to what some may think, the prepayment plans showing the highest rate of progress in reducing the proportion of the population without protection tend to be those that have the highest benefits — that is, those that most nearly pay the hospital bill in full. Rate of progress is also related to past success in reaching large segments of the population. Prepayment agencies appear to be reducing the proportion of the uncovered population faster in areas where a relatively high per cent of the population already participates. The statewide prepayment plan that has the highest monthly rates and that also has one of the highest benefit structures is the plan which in the last three years has made the biggest dent in covering the uncovered population. When we say, as we can, that prepayment organizations with a high per cent of the population already in prepayment, with high monthly rates and high benefit standards are among the plans that tend to show the fastest rate of progress in reducing the proportion of the population without protection, we must reconsider many of our past conclusions with respect to the potentialities of all types of prepayment.

There are many implications for the hospital administrator in the expansion of prepayment to the entire community. Reliance on prepayment establishes the hospital in a new and more positive community-wide rôle. Prepayment has widened the hospital universe; it is no longer four walls and their contents. Rather, it extends throughout the geographical area served by prepayment and into the social and economic environment in which the hospital and the prepayment agency function.

Along with the new economic tools which the hospital now possesses has come an even greater rôle in community affairs. The shift in source of hospital income from the sick paying their bill at the time of illness to payment from a pooled fund created primarily by the well people in the community creates a new set of relationships and a new set of responsibilities.

Prior to development of prepayment the hospital economy was primarily concerned with patients and with those groups in the community financially able to supplement patient income with large and small philanthropic gifts.

Every month every person in the community participating in prepayment is made hospital conscious, whether the payment is a deduction from wages, paid by check, or paid by the employer. The well people as well as the sick share the financing of the community hospital system. A monthly increase in prepayment costs means that every person in the community covered by prepayment is affected, not just the sick.

A significant implication in the general use of prepayment is that, for the public, hospital costs are translated from per diem costs to the monthly cost of prepayment. In communities where 50 per cent or more of the population now has prepaid hospital care, hospital charges are far less meaningful than the monthly rates charged for prepaid protection. The cost to the hospital of providing a day's care is of far less interest to the public today than is the monthly prepayment charge. With 80 per cent or more of the hospital income coming from third-party agencies, already true for some hospitals, per diem costs are a matter of direct concern only to the hospital and the third-party agencies, not to the public.

One of the effects of this change may be vividly seen in the attitude of the hospital administrator toward occupancy rate. Heretofore, occupancy rates have been viewed by hospital administrators as a factor affecting per diem costs; high occupancy has meant lower costs; low occupancy, higher costs. But with increased dependence on prepayment for financing, reduced occupancy rates resulting from careful selection of patients for admission and from shorter length of stay could permit a lowering of the monthly cost of prepayment. Thus lower occupancy rates, rather than higher occupancy rates, become the objective of the hospital administrator wanting to bring prepayment to a larger number of people.

Prepayment rates might also be affected favorably if physicians could refer private patients for diagnostic services on an outpatient basis with the same safeguards and quality of care now assured when they are admitted for inpatient diagnostic services.

Industry has found that full utilization of plant and equipment tends to lower costs because capital invested

More Service Justifies Higher Charges

THIS article spotlights the importance of prepayment as a method of extending service to patients yet assuring financial solvency of hospitals. The public, while generally pleased with the science of medicine, still has 1935 ideas of what this service should cost. Hospitals have done a poor job of explaining their increased costs. Prepayment in many instances has made it difficult for hospitals to keep abreast of service requirements. To be truly effective in answering the fiscal problems of hospitals, prepayment must be related to costs. Hospitals, in turn, need to establish sound fiscal methods based on cost accounting which will permit satisfactory cost analysis. Widespread use of prepayment will make the community more conscious of premium cost than of per diem costs.

The few prepayment plans which have expanded their horizons of service and benefits have increased their community coverage *even though premiums have been increased.* Provisions must also be made to cover the expanding ambulatory and preventive aspects of medical care in prepayment plans. Many hospitals and prepayment plans are totally unprepared to meet an expansion of service to subscribers. Implementation of the Magnuson Report with reference to expansion of prepayment coverage for medical care would find most hospitals unprepared to meet demands for service.

Hospitals and prepayment plans must coordinate their strengths in the best interests of the patient. Services to patients must be expanded to create a more favorable climate for the scientific and preventive phases of medicine. "We should expect to improve our prepaid benefit standard and our hospital services at a rate at least comparable to the increase in purchasing power," Mr. Becker has said. This is opposed to the statement, so frequently heard, that we cannot increase charges to the patient. We cannot extend service without some increase in cost, but, as an improved product receives public recognition in the form of increased purchases, in industry, improved hospital service will increase public acceptance of hospital charges.—MADISON BROWN, M.D.

is used more largely. Hospitals might find they can lower the monthly cost of prepayment by increasing the pay roll to provide week-end and evening services in some departments. Economical operation under prepayment means the most effective and efficient use of the hospital, even should total expenditures per patient day increase.

While the hospital administrator has responsibility to take every step to assure efficient and economical administration, without jeopardy to quality of care, he has, in exchange for the underwriting of his budget, by prepayment, other responsibilities to the prepayment organizations and their public.

One responsibility is the introduction of uniform cost accounting methods to permit cash analysis and an equitable basis for determining the amount of payment to hospitals and hospital charges. The prepayment plan must pay the hospital on a basis directly related to the cost of services to avoid hospital deficits and to avoid subsidizing the nonprepaid patient. Cost accounting methods also help to develop a basis of payment that assures the hospital full reimbursement from public welfare agencies for services provided.

With prepayment as the common method of paying for hospital care, uniform hospital cost accounting and methods for determining amount of payment to hospitals by third-party agencies assume increasing importance. Formerly, the adequacy of funds for payment of care to beneficiaries of public welfare agencies was not a major concern because these payments could be supplemented in various ways. Today, with hospital charges and income generally tending to be related to cost of providing services, the deficits on public welfare cases are of mutual interest to the hospital, the prepaid patient, and the public. Likewise, how the aged and other groups unable to pay the cost of prepayment are to meet their hospital bill is of concern both to prepaid patient and hospital.

In day-to-day administration hospitals focus on balancing the objectives of effectiveness and efficiency against income and expenditures, but there are two other tasks that must command the attention of the hospital administrator and the governing board: (1) joining forces with all community agencies to tell the story of hospital costs, and (2) building stronger community programs for financing hospital care.

These two tasks are intertwined. They both require reaching the total community. They are tasks the individual hospital cannot accomplish.

Hospitals acting together would render a public service if they would recommend a basic, or several basic, benefit standards which would assure protection to the public and at the same time give the hospitals the income needed. Hospital administrators cannot be unaware of the relationship between the benefits made available to the community and sufficient hospital income. Greater uniformity in the level of benefits available to the public would increase public confidence in prepayment and would assure the hospital of more nearly adequate financing, not to mention decreasing the amount of administrative detail in the hospital billing office.

The public is forced to select a benefit plan from among the hundreds of alternative possibilities made available by the many agencies offering prepaid hospital protection. Not knowing the actual risk involved against which protection is sought, the public is at a great disadvantage in selecting a benefit program except by the price tag it carries or by a few familiar or unusual features. The adequacy of benefits is not necessarily measured by price.

Nor can hospitals be unconcerned with the rate of progress made by the prepayment agencies in reducing the proportion of the population without prepayment, since this directly affects hospital financing. The more people covered by prepayment protection, the more solid the financial foundation of the hospital.

Today the cost of prepayment is as much a community concern as the cost of telephone service, electricity and water. This wider concern with hospital financing means more coordinated community planning, not less. The hospital administrator must become more aware that his hospital is an essential part, but only a part, of the total community pattern of service. The very success of prepayment in the community depends on the amount of effort he contributes to interpreting the prepayment concept and the effectiveness of his cooperation with other groups.

Interpretation to the community of the need for prepayment is a job for all hospitals acting together through state and regional hospital associations and working in cooperation with the prepayment agencies. It requires mobilization of total community effort. The rewards for the public are the assurance that when hospital care is needed it will be available, that it will be good care, and that there will not be economic barriers to it.

Care of the Aged Is Major Problem

HOSPITAL care in America is underfinanced because we have not made adequate provisions for the individuals and families unable to purchase prepaid hospitalization protection. This problem was keynoted by the Rt. Rev. Msgr. Donald A. McGowan at a national workshop conference on financing hospital care for nonwage and low income groups, held in Chicago under the auspices of the Commission on Financing of Hospital Care, April 24 and 25.

"Voluntary hospitals and public and private welfare agencies are daily confronted with persons needing hospital care but unable to pay for it," Msgr. McGowan told 75 leaders in the fields of industry, labor, welfare, medicine, and hospital care. He emphasized the need to find methods for assisting the marginal income groups who are unable to purchase prepaid hospital care, or who, because of their social and economic circumstances, or because of deficiencies in present prepayment plans, are not now protected by prepayment.

Conference participants, meeting in three discussion groups, considered ways in which more nearly adequate provisions could be made for strengthening the financing of hospital care for the nonwage and low income groups. Their conclusions will be studied by the commission before it formulates its report and recommendations to the American people.

Among the principal facts brought out at the conference were the following:

Older people are less able to pay for hospital care than are those in other age groups; the group 65 and over is increasing at a faster rate than is any other age group in the population; older people have more disability and its duration is longer; they require more hospital service than other age groups do.

The number of persons 65 and over receiving social insurance benefits or public assistance in 1952 was approximately 6,800,000—about two-thirds of the aged who were not employed.

The unemployed and their dependents constitute a major economic hazard when illness strikes. This hazard threatens not only the family involved but the hospital and the community itself. Often the unemployed and their dependents are not covered by prepayment and generally are not able to pay their hospital bill at the time of illness. During periods of unemployment families not only have less ability to pay for hospital care, but are likely to make greater use of hospitals.

DAVID GOODMAN
Milwaukee

At the Shortell Fracture Clinic

Orthopedics Comes Into Its Own

A SPECIAL fracture clinic, believed the largest of its kind in the world, was recently dedicated at Boston City Hospital—an instructive example of specialization of facilities that might well be studied by other hospitals.

Built at a cost of $500,000, the Shortell Fracture Unit, named for the late Dr. Joseph H. Shortell, who was chief of the hospital's orthopedic service, incorporates (1) a splint room, (2) its own x-ray department with portable and stationary equipment, (3) an x-ray-equipped operating room, (4) a plaster unit, (5) a special photography department, where unusual fractures cases are studied, and (6) a conference and teaching room for student use, where lantern slides and movies are available.

The new unit approximately doubles the original 25,000 square feet of space available for orthopedic work at Boston City Hospital, Dr. James Manary, superintendent of the hospital, explained. Incorporated in the completely new x-ray department are two diagnostic x-ray units, a fluoroscope, and two mobile x-ray units.

The clinic is staffed with 14 visiting orthopedic surgeons, and one full-time teaching fellow with a house staff of 12 residents and interns. The x-ray department will have a staff of 15, with its own radiologist and resident radiologist.

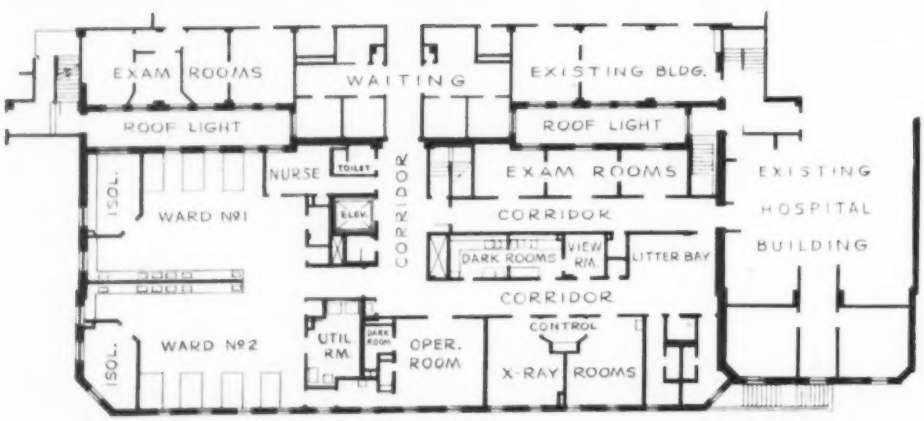
The expansion was required by the growth in orthopedic patient load of about 10 per cent per year in the last several years. The present hospital orthopedic load is about 15,000 patients per year, of whom 4000 are fracture cases, 500 requiring operative procedures. Thanks to the new expansion, the fracture unit will be able to handle all of the orthopedic cases, plus a 100 per cent increase in load.

The new plaster room, located adjacent to the shock room and ambulance entrance, is designed to handle 50 patients at one time. The department makes its own plaster bandages and stores several months' supplies of these and splints in stainless steel vaults for its own and other hospitals' emergency use.

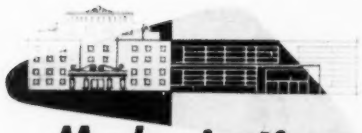
All orthopedic teaching of the Boston University Medical School and Tufts Medical School are carried on at Shortell.

The Shortell Fracture Unit has developed from the original idea first promulgated by Dr. Frederic J. Cotton, founder of the hospital's orthopedic service. This idea was to create an independent surgical service for bone fractures in a separate building, housing complete x-ray and other specialized equipment needed for effective fracture work. Thus began 20 years of planning which culminated in completion of the new fracture unit.





Left: Plan of the new clinic. Above: Shown on a tour of inspection are (l. to r.): A. M. Moloney, M.D., chief roentgenologist, and James W. Manary, superintendent, Boston City Hospital. Nursing Supervisor Edna Kolus is seen at work at her desk.



Modernization

They Built a Hospital Around a Hospital

1. *To provide ample space for every service*
2. *To group all outpatient diagnostic and therapeutic facilities*
3. *To put nursing offices and classrooms on one floor*
4. *To separate pediatrics from the main stream of traffic*
5. *To provide for additional floors in the future*

W. C. PERDEW
Superintendent, Bronson Methodist Hospital, Kalamazoo, Mich.

TO REBUILD an entire hospital plant floor by floor while continuing to care for patients is a thrilling adventure, though somewhat wearing at times, and that is just what Bronson Methodist Hospital, Kalamazoo, Mich., did between 1948 and 1952.

The hospital consisted of three brick buildings of fire-resistant construction. The oldest was erected in 1905, and has been used in recent years as a dormitory for freshman student nurses, with the exception of the first floor which housed hospital service departments. To this building an addition had been erected in 1928 consisting of four floors. On the east end of this addition another building of seven floors was constructed in 1940. The total capacity was 140 beds plus 30 bassinets.

Our building program began in 1948 and was completed in 1952. It included five units of construction: the remodeling of all old hospital areas and the erection of the service building, the new power plant, the main hospital addition of six floors and basement, and the medical center, with offices for 32 doctors on the second and third floors and hospital areas in the first floor and basement.

Our basic problem was to modernize the old buildings, relocate departments for efficient functioning, enlarge and integrate them with the total hospital plant so as to establish adequate services for a minimum of 260 beds and 43 bassinets, provide a reserve of space for further expansion in the future, and at the same time continue to care for our patients. To accomplish this, the timing of the various phases of construction had to be carefully planned.

The first unit was the service building erected south of the 1940 and 1928 buildings. This gave us a loading dock and receiving room through which supplies could be brought into the hospital without interfering with the construction of the larger quarters. Our maintenance department, volunteer service and print shop had been located in some old buildings standing on the site where the new main addition was to be built. When the laundry moved into its new quarters, the maintenance department and print shop occupied the space thus vacated and the volunteer service moved into its new quarters on the second floor of the service building. This allowed us to clear the site for the main addition.

The completion of the service building also allowed us to gather up the boxes, bales, cartons and barrels of hospital supplies from the stacks which had lined the first floor corridors and filled miscellaneous little rooms here

Below: The school of nursing library before remodeling, and (bottom) after remodeling.



and there, and bring them all together in the new general storeroom where they would be under adequate control.

The second unit was the power plant. The old power plant consisted of two coal-fired boilers in the sub-basement under the east end of the 1940 building. Inasmuch as new construction would block the conveyance of coal to these boilers, they were converted to oil one at a time during the summer of 1949. The new power plant contains a water tube boiler with tested capacity of 30,000 pounds of steam per hour, coal-fired with a pneumatic stoker. The old smoke stack was an integral part of the 1940 building. We were able to use it for the larger boiler by the installation of an induced draft fan, thus saving $5000 as compared with the cost of building a new stack.

The next unit constructed was the medical center which incorporated the new public entrance and lobby, hospital business offices, and such new hospital services as chapel, snack bar and pharmacy.

The fourth unit to be erected was the main addition. The first portion of the main addition to be occupied was the sixth floor containing 20 private rooms. When this floor was completed, the wall of the 1940 building was broken through so as to join the old and new corridors.

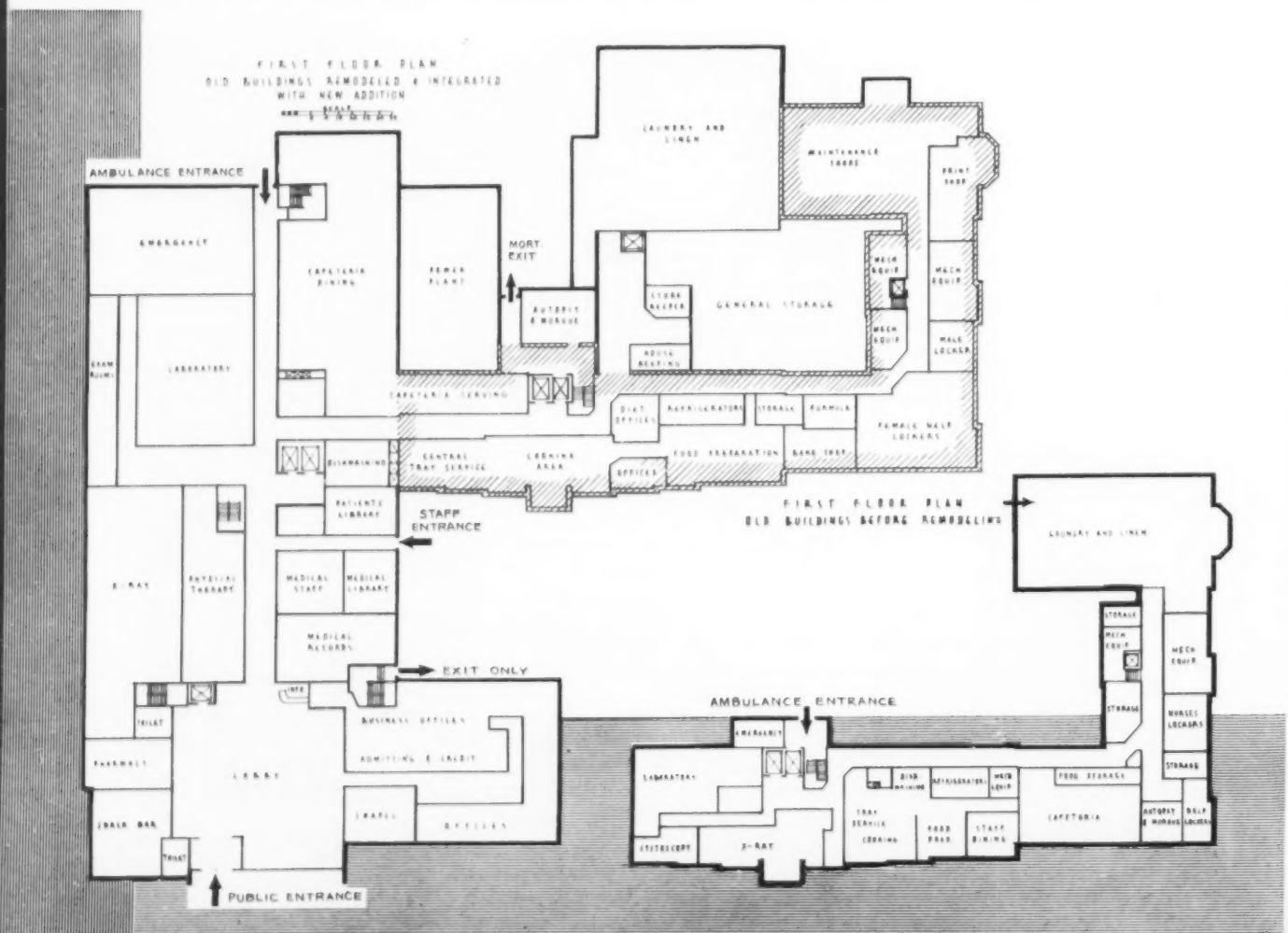
The entire south wing of the fifth floor of the new addition is now occupied by central service. As soon as central service department had its new equipment operating satisfactorily, it gradually took over all the sterilizing for the hospital, including operating rooms, obstetrics and formulas preparatory to the remodeling of these areas.

The first floor of the new addition was completed next. The laboratory, x-ray and cystoscopy departments vacated their locations in the old building, thus permitting the east end of the first floor to be remodeled for the new dietary tray service, expanded kitchen and cafeteria. Later on this allowed the shifting of kitchen and tray service activities from the old dietary dumb-waiters to the new ones so as to provide trays for the patients being moved into the new addition.

The new emergency department on the first floor of the main addition was prepared for temporary occupancy as an operating room suite, including cystoscopy. The three emergency operating rooms were used as major rooms and the two recovery rooms as minor rooms; the public waiting room was used as a surgeons' lounge. This permitted the surgical suite on the fifth floor of the old building to be vacated for remodeling.

By the time the old fifth and sixth floors were remodeled, the second, third and fourth floors of the new building were ready to receive patients. All obstetrical patients were moved out of the old building west of the old labor and delivery suite and all babies were moved to the new nurseries in the north wing of the main addition. As soon as the new

Plan of the first floor, before (lower right) and after. The remodeling and integration project provided separate entrances for the emergency room and the autopsy area, and grouped kitchen and serving facilities on one floor.



labor and delivery suite was ready for patients, the old labor and delivery section was remodeled into private and semiprivate rooms.

On the third floor of the old buildings, the patients from the two surgical nursing units were moved into the new building. The pediatric patients were moved down to the second floor of the old building, temporarily occupying the space from which the patients on the medical nursing unit had been moved into the new building. All the rest of the second floor of the old building was now completely vacated for remodeling. The medical records department moved to its permanent location on the first floor of the main addition and two private rooms on the second floor of the new building were used for temporary nursing offices.

With most of the hospital patients transferred to the new addition, the new dietary tray service and dumbwaiters were put into operation. At the same time the new cafeteria was opened, thus making possible the remodeling and expansion of the old kitchen areas.

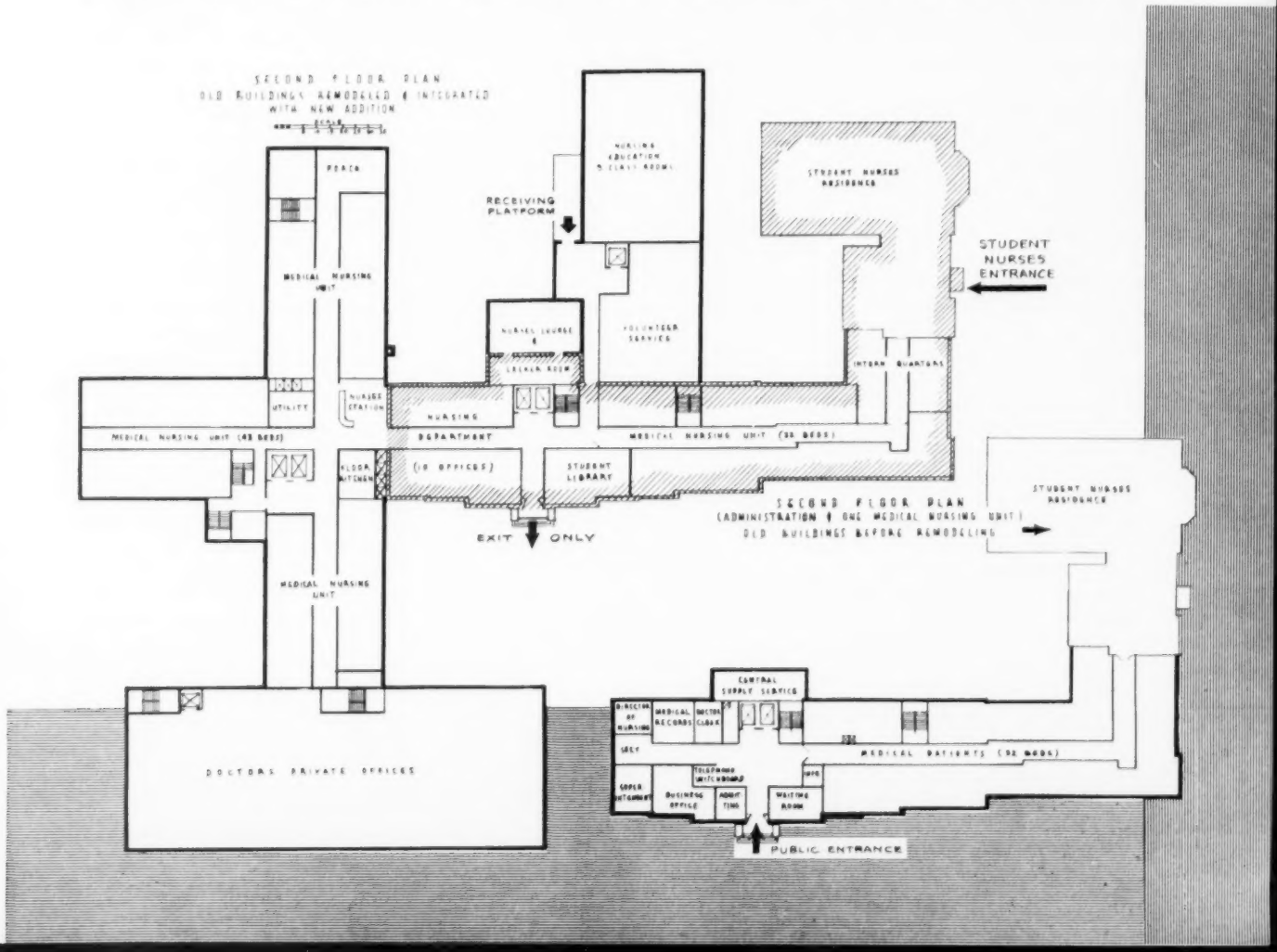
From this point on the tangled situation gradually unwound as the remodeled patient areas of second, third and fourth floors were reoccupied. The last areas to be completed were the west end of the second floor, the corresponding area on the first floor, including the dietary department, formula preparation, employe locker rooms, and necropsy suite, all of which were completed and reoccupied within the space of about three months.

One of the main objectives of the remodeling project was to bring the facilities of the old buildings up to the modern standards incorporated in the new addition. Few patients' rooms in the old building had toilets. The remodeling provided a toilet in every patient's room except three on the second floor where the installation of toilets was found to be impossible. All patients' rooms were provided with wall-hung, fluorescent bed lamps, and oxygen was piped into every room.

Doors were widened from the previous 32 inches to 48 inches. Asphalt tile corridor floors were replaced with rubber tile and all corridor ceilings received acoustic tile installations. All wood and metal furniture from the old building was refinished in the new maintenance shops, which are equipped with stripping tank and paint-spray booth. The pneumatic tube system incorporated in the new addition was extended to all necessary points in the remodeled buildings, the tubes being run exposed on the old corridor ceilings and painted to match. The new hospital dial telephone system was also extended throughout the old buildings.

The total cost of the general contract, architectural and consultant fees for the entire construction and remodeling program was $3,310,000, of which $485,000 was the cost of remodeling and modernizing the old buildings.

The second floor was one of the last sections to be completed. It now houses the nursing offices and classrooms, students' residence, and interns' quarters. In the new addition are private offices for doctors and a 43 bed nursing unit.



The Strange Case of Dr. Loyal Davis

GREER WILLIAMS

Director of Public Relations
American College of Surgeons
Chicago

THE principles of medical ethics of the American Medical Association are designed to guide a physician in determining his moral duty to his patients and to other doctors.

As does all ethics, these principles find their *raison d'etre* in the fact that mankind, of which doctor-kind is a component part, is hopeful of doing right but is vulnerable to the temptations of wrongdoing. For example, the A.M.A. code in one place (I, 4) warns: "Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical," and in another place (III, 4) says: "A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession."

PRINCIPLES PRESENT PARADOX

These two principles, the one seeming to advise the private practitioner to shut up and the other, to speak up, present something of a paradox to the physician who must risk charges of disloyalty to his profession to observe his higher obligation as a citizen of a nation constitutionally committed to the right of protest.

Such, at any rate, was the dilemma posed last winter in the Chicago Medical Society when charges of unethical conduct were brought against Dr. Loyal Davis, a member of the board of regents of the American College of Surgeons; editor of the scientific journal *Surgery, Gynecology and Obstetrics*, professor of surgery at Northwestern University Medical School, and chief of surgery at Passavant Memorial Hospital.

As public relations director of the American College of Surgeons, I must claim some responsibility for the event provoking these charges. Among the dozen or more science writers and reporters covering the 1952 clinical congress, held last September in New York City, certain ones requested the opportunity to discuss in a frank manner with the regents of the college the perennial problem of fee-splitting between surgeons and physicians who refer them patients.

The college has manifested a steadfast concern over this unethical practice ever since American surgeons organized themselves for the purpose of elevating their standards in 1913. For forty years, the college has sought through professional channels to persuade surgeons not to split fees, a practice condemned in the A.M.A. principles of medical ethics (I, 6) equally as much as in the A.C.S.'s fellowship pledge.

The splitting of the surgeon's fee with a physician who refers him a patient is an inducement that has been recognized, both in its simplest form and all its many variations, as a violation of still another A.M.A. principle of ethics which states: "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration" (I, 1). However acceptable the finder's fee may be in commerce and industry, in medical practice, such a kickback is a breach of the patient's trust that his doctor will examine his condition and give it his best judgment, unintluenced by the desire for financial gain. In short, a family doctor's choice of a surgeon for his patient should not be influenced by either one's opportunity for profit. While it is conceivable that reasonably honest and competent doctors might split the surgical fee under some such guise as the general practitioner's assisting in the operation and hospital care, which are the surgeon's responsibility, the mere existence of a division of the surgical fee in a referred case constitutes a pressure to break down medical conscience instead of to support and to reinforce it. Ethics, in its nature, must close doors rather than open them.

SURGEONS MUST SIGN PLEDGE

The college, as the reporters subsequently were told, actively has sought medical obedience to the ethics which emphasizes that doctors attending patients should render separate bills. It has required each fellow of the college to sign a pledge that he would practice in an ethical manner. It has required hospitals approved by the college to exact a similar pledge from all members of their professional staffs.

These measures have proved effective in some instances and ineffective in others. The signing of a pledge has reformed some and has made hypocrites of others. On the other hand, much surgery is performed by physicians who have not met the qualifications of the college and many hospitals have not met the standards of the college or its successor, the Joint Commission on Accreditation of Hospitals.

It is common knowledge that fee-splitting, unheard of in some parts of the country, is deeply rooted and, indeed, the prevailing mode of practice in other sections. No honest, well-informed man can deny this, although the extent of fee-splitting has been fairly successfully kept from the public in these communities until recently. If the proof were needed, which it is not, an accurate index has emerged in the efforts on the parts of some members of various state and local medical societies in the Middle West, including the Chicago Medical Society, to change the code of ethics and make

This article will appear in the July-August Bulletin of the American College of Surgeons.



AMERICAN COLLEGE OF SURGEONS OFFICERS discuss fee splitting with science writers at 1952 Clinical Congress, New York City, Sept. 24, 1952.

SEATED AT TABLE, Left to right, beginning with man whose back is to camera: Jack Geiger, INS; Jack Nolan, *Philadelphia Inquirer;* Milton Silverman, *San Francisco Chronicle;* Arthur J. Snider, *Chicago Daily News;* Alton Blakeslee, AP; Delos Smith, UP; Severino P. Severino, *Cleveland News;* Don Dunham, *Cleveland Press;* Dr. Herbert Willy Meyer, chairman, public relations committee; Dr. Evarts A. Graham, chairman, board of regents; Harold L. Foss, 1953 president; Alton Ochsner, 1952 president; Loyal Davis, regent (inset); Newell W. Philpott, regent (obscured); Howard A. Patterson, member, local committee on arrangements; Arthur W. Allen, former chairman, board of regents; Joseph Tenopyr, governor; Frank H. Lahey, governor; Joel W. Baker, 1952 second vice president. (At near end, two staff secretaries). Seated against opposite wall: Dr. Jere W. Lord, vice chairman, public relations committee, and Dr. Paul R. Hawley, director of the American College of Surgeons.

fee-splitting ethical where the general practitioner assists the surgeon in the operation and hospital care of the patient. In the face of this effort, the A.M.A. judicial council reenunciated its interpretation of this practice as unethical.

From time to time, the American College of Surgeons officially has sounded public warnings against the evil of fee-splitting. It was in this spirit of conscientious concern and sense of social responsibility that its regents and other officers met with the press on Sept. 24, 1952. Those present included the chairman of the board of regents, the president of the college, the president-elect of the college, the immediate past chairman of the board, two other regents, two members of the board of governors, the 1952 second vice president, the chairman and vice chairman of the clinical congress public relations committee, and one member of the local committee on arrangements. These 12 gentlemen, plus the director of the college, who played no active part, sat down around a conference table with eight members of the press, including several of the nation's leading science writers.

The conference was reported as being unprecedented, and this was substantially correct, as were virtually all news accounts of the meeting that I have read. Never before, to my knowledge, had the responsible officers of the college or, for that matter, any other national medical organization, had the willingness, let alone the courage, to submit to a round-table discussion of medicine's sins with the press representatives of those who had been sinned against — that is, the patient-public.

The questions put by these press representatives were sharp and to the point. The reporters wished to know what was so bad about fee-splitting, what the college was doing about it, and what the public could do. They wanted to know just where fee-splitting existed.

One regent, Dr. Loyal Davis, ventured to state: "There is no question but that fee-splitting is on the increase in Chicago and surrounding areas." In the course of the discussion, the regents put much emphasis on the fact that one unfortunate feature of fee-splitting in any community is that it works to exclude the young, well-trained, ethically conscientious surgeon

seeking to establish himself in a community. "If he refuses to do it, he starves to death," said another regent.

It was plain that this was a factor that greatly distressed officers of the American College of Surgeons. Having done everything to encourage young physicians to obtain competent training in scientific surgery, they repeatedly had received complaints from these men—who could offer the patient a far higher chance of a satisfactory result than could those with lesser training—that they were subject to discrimination and trade-union tactics. Thus, fee-splitting not only worked against the immediate best interests of the patient by introducing a financial consideration in choice of surgeons but against the general public benefit derived from elevating the quality and improving the results of surgery.

The public and the professional reactions to this conference were at some variance. In addition to news stories published in a minimum of 338 newspapers, 36 carried editorials. With only three exceptions, all strongly supported the college's position.

PRESS COMMENDS COLLEGE

"Good work, doctors! The American College of Surgeons is to be commended," said the editorial in the *New York World-Telegram.* "We like the spirit of the American College of Surgeons," said the little *Austin Herald* in Minnesota. The *Atlanta Journal-Constitution* said: "The American College of Surgeons does well to bring the practice into the open, brand it for the fraud it is, and lead in an intensified fight to banish it. When a profession cleans its own house, it minimizes, incidentally, the danger that the people will lose patience and call on the government to conduct the cleansing operation." Said the *Cleveland Press:* "The aggressive attitude of the College of Surgeons will do much to inspire public respect and confidence."

Spoke the *Boston Globe:* "It is rare indeed when the leaders of any group initiate a reform to apply to persons in their own line. The board of regents of the American College of Surgeons, which did so, deserves great credit for the announced campaign to educate the public concerning fee-splitting. . . ." The *Madison State Journal* in Wisconsin pointed out: "Ordinarily, it is not considered 'good medicine' for doctors to diagnose their own ills, but in this case, an exception must be made. . . . It is well for the doctors to clean up their own house on this matter. If the medical profession does this clean-up job itself, it will avoid the government interference that neither the medical profession nor patients desire." The *Hackensack Record* in New Jersey told the public: "You're the detective. The American College of Surgeons, treading on one of the medical profession's touchiest toes, says that fee-splitting is an unethical practice, hard to detect, and harmful to the patient. This much everyone knew. What gives hopes that the evil may be curbed is the frank manner in which the college has discussed it and asked the public to help. Hitherto fee-splitting has been like venereal disease was a few years ago; it existed, but nice people did not talk about it. . . ."

Some physicians did not seem to appreciate the college's good intentions, much less its good press. According to hospital-corridor gossip, certain Chicago general practitioners were particularly stung because patients had asked them if they split fees. Just why a patient's wish to reach an understanding with his doctor on the financial arrangements covering his case should prove embarrassing was not made clear.

Approximately 150 physicians, all members of the Chicago Medical Society, most of them general practitioners and a large number from the staffs of two hospitals, signed petitions charging Dr. Davis with (1) making statements for personal publicity advantages, (2) releasing misleading information, and (3) making statements detrimental to the entire medical profession. These doctors called upon the society to investigate and expel Dr. Davis. They also released information to the press on their accusations, and this information was duly publicized on Dec. 18, 1952, in the same Chicago newspapers that had carried Dr. Davis's statement at the New York conference of regents and reporters.

It was not until Jan. 19, 1953, that Dr. Davis received official notification of the charges placed against him. He was summoned to appear on January 28 before the society's committee on ethical relations to defend himself. Meanwhile—indeed, immediately following the attack on Dr. Davis—the press came to his defense.

Said the *Chicago Sun-Times:* "Too frequently it has been the policy of individual businessmen and certain business organizations to complain bitterly against criticism rather than do their part toward correcting the conditions criticized. It doesn't take a particularly smart man to recognize that this is the wrong approach.

"Chicago doctors currently are supplying another example of this type of attitude. . . . If they had asked the Chicago Medical Society to make an impartial investigation of the matter and then make public its findings, they would have attracted public support. As it is, one gets the impression that they are attempting to cover up, that they would silence all further criticism by those on the inside who know the facts. . . ."

Said the *Chicago Daily News:* "Physicians as a group . . . still have much to learn about the art of public relations. An illustration is the ill-timed and unwise attack on Dr. Loyal Davis. . . . The ouster effort seems to be a sanctimonious attempt to silence a critic without bothering to refute his charges. The energy would be much better spent in combating the evil of which Dr. Davis complains. It is the Dr. Davises, and not their attackers, who gain public support for the profession in its battles over the drives to socialize medicine. . . ."

EVIL HAS BEEN LESSENED

Said the *Chicago Tribune:* "One of the principal aims of the organizers of the American College of Surgeons, many years ago, was to wipe out fee-splitting. . . . The evil has been lessened, but, as the conversations in New York make clear, it has not been eradicated.

"Dr. Davis was not sounding off on some curbstone when he said that the practice seems to be increasing in Chicago. He was speaking at a news conference with science writers, organized by 13 officials of the college, who spoke in its name, to organize public opinion against a practice that hurts the public.

"The medical gentlemen who want to take reprisals against Dr. Davis are trying to indict the prosecutor. Dr. Davis is not given to rash or ill-considered statements, and if he says that fee-splitting exists in Chicago, his statement will be generally accepted as the truth. The medical society should be taking measures to stamp it out and the more responsible members, it can be predicted, will do so. . . ."

In the subsequent hearing before

(*Continued on Page* 138)

Untangle Those Lines of Authority!

The first step is to decide who gives orders to whom

PAUL J. GORDON
New York State School of
Industrial and Labor Relations
Cornell University
Ithaca, N.Y.

THE maid reports to the housekeeper concerning her work assignments for the day or week, concerning her pay, time off, discipline and so on.

On a given day the maid is assigned to a general ward to perform the duties outlined for her by the housekeeper. As she works, she also meets, in the ward, patients, doctors, nurses, nurse's aides, possibly the administrator or other department heads. She finishes her assigned work in the ward and at the same time one of the patients becomes ill, soiling the bed and floor and upsetting glassware and supplies on the night table—all of which require cleaning the area over again.

WHOSE JOB IS IT?

From the organization point of view, what problems are created? Whose job is it to clean up the bedside area? Whose job is it to give directions so that the cleaning will be done? Does the head nurse telephone the housekeeper so that the housekeeper can instruct the maid? Suppose the head nurse is occupied with other work. Can the doctor give orders to the maid? Can the maid refuse to perform the work unless directed by the housekeeper?

Consider the second illustration:

A hospital dietary department has established centralized tray service. Trays are completely set up and prepared in the main kitchen, then sent to the floors for serving.

One dietary worker has the principal duty of assisting in serving portions of cold food and placing servings on the trays. Owing to illness and turnover the dietary department is shorthanded at the cafeteria counter during the noon hour. This employe is assigned to serve behind the cafeteria counter which is supervised by an assistant dietitian in charge of cafeteria service.

Before taking the new assignment, the employe reported to an assistant dietitian in charge of the main kitchen and also carried out any instructions given by the head dietitian.

As the noon hour service proceeds, one of the diners complains to the cashier about slow service given by the reassigned dietary worker.

Again, a number of organization questions arise that cannot easily be answered by any formula of organization or by an organization chart. Can the cashier forget the matter? If the cashier elects to act, whom should she address: the employe, the assistant dietitian in charge of the cafeteria, the assistant dietitian in charge of the main kitchen, or the head dietitian?

Certainly no formula exists for answering the foregoing questions. Broad principles of organization developed in schools of engineering and schools of administration do not always lend themselves to easy application in cases such as those of the maid and the dietary worker. However, these are the questions of responsibility, authority and organization that often constitute barriers to more effective coordination among hospital employes and supervisors. These are the practical, down-to-earth questions that seemed to be of interest to administrators, assistant administrators, and department heads in three nonprofit, short-term general hospitals recently surveyed by staff members of the New York State School of Industrial and Labor Relations at Cornell with the cooperation of the Central New York Regional Hospital Council, Inc.

Both the case of the maid and the case of the dietary worker offer examples of problems that arise in hospitals and these problems would probably arise even if it were possible to devise some utopian scheme for hospital organization.

The foregoing cases both point to the need for supervisors and employes to understand, as a minimum, two things about authority and order-giving in hospitals.

The first is the need to understand the ultimate source of authority for orders and instructions. If the ultimate source of authority is the need of the patient, then it scarcely matters who gives the orders. The question becomes one of patient need, rather than some ancillary issue like lines of authority, job description or supervisory personality. This type of understanding is not necessarily part of the knowledge and mental attitude of every supervisor and employe. It should, however, be part of a person's orientation to a hospital job.

DECIDE SOURCE OF AUTHORITY

The second need is to set up an understanding of formal organization authority clear enough to protect the hospital, the supervisors, the employes and the patients from complete confusion when the foregoing concept of patient need breaks down. If patient need were the only source of authority for orders, everyone in the hospital might interpret patient need in his own way. Then any single supervisor or employe could be besieged by numbers of simultaneous and even conflicting orders. Experienced hospital people can testify to the existence of such situations.

The balance between wholesale confusion, everyone giving orders, and no cooperation, "I listen to my supervisor and no one else," is a difficult one to maintain.

Therefore, if there is an answer, or an approach to an answer, it probably lies in this direction. During his orientation to the job, the employe should learn who is his immediate supervisor, the person he goes to with his problems, the person he goes to if he has a gripe, wants a raise, or wants to take some time off.

He should understand that he is obliged to cooperate with other supervisors. He should understand that if he receives numbers of simultaneous or conflicting orders he should then consult with his supervisor who will help him out, bail him out, act as referee, assist him in keeping a good working relationship with those whom he can please, and those to whom he must say "No."

In hospitals, as in other organizations, the question, "Who is my boss?" has no clear answer for many employes. This particular kind of confusion probably contributes more than hospital people recognize to the turnover among new employes. It also contributes to patient misunderstanding of working relationships in the hospital. It certainly does not contribute to improved patient care.

ORGANIZATION CHARTS NEEDED

Recognizing that organization charts and organization analysis do not solve problems of themselves, and do not necessarily picture the way an organization really operates, department heads who were consulted nevertheless felt that the problems arising out of misunderstanding or inadequacy of formal organization could be reduced with sufficient study and effort. A number of department heads recommended the drafting and distribution of up-to-date organization charts as a helpful starting point in reducing unnecessary confusions and frictions on questions of authority.

By way of an approach, hospital administrators and department heads have mentioned the following items as part of possible agenda for improving organization:

1. Drafting of a chart of organization for the hospital and for individual departments.

2. Reexamination of hospital structure and individual jobs to assure that clear lines of responsibility and authority have been established.

3. Identification of problems that grow out of misunderstandings relative to present lines of organization, responsibility and authority.

4. Identification of problems that grow out of needs for clarifying, modifying or completely revising present lines of responsibility and authority.

5. Examination of the span of control imposed on each member of the supervisory staff, that is, the number of employes, separate units, sections or departments involved, and also the number of levels of hierarchy within each department and within the hospital.

6. Examination of every job wherein employes must accept orders or instructions from several sources; if possible, to reduce the number of people pressing orders on one employe; and, in any case, to make clear to each employe the single person to whom he is ultimately responsible when clarification and appeal are necessary.

7. Recommendations for changes in organization aimed at increasing coordination and at reducing misunderstanding relative to responsibility and authority.

8. Education of employes and supervisory personnel to assure adequate notice, understanding and acceptance of organization changes, and full knowledge of the established lines of responsibility and authority relative to every employe's job.

9. Recognition that overemphasis on the mechanics and channels of formal organization may block or delay communication and coordination among hospital employes, that people in the hospital will necessarily develop their own pattern of work relationships in order to get work done, that the formal organization may have to be modified to achieve maximum coordination of effort in the hospital.

Although organization analysis should help in uncovering possible sources for some of the problems of coordination and communication within and among hospital departments, the analysis may not of itself reveal approaches to a solution.

SERVES ONE MASTER

To an extent, hospitals may be overlooking some important psychological aspects of organization that industry has taken time to learn. The "organization principle" that industry has tended to recognize, and that hospitals may have neglected at the top management level, is called "unity of command," namely, that the department head shall not be obliged to serve more than one master—and that if dual supervision is necessary, the department head will clearly understand whom it is that he may appeal to when a final source of clarification of his own status is needed. When the department head or supervisor lacks this type of support, his personal motivation and his effectiveness as an executive of the hospital may be considerably lessened.

To the confirmed advocate of industrial organization "principles," the complexity of hospital organization, the doctor with authority in the hospital but little direct responsibility to the hospital organization, and the lack of clearly defined and accepted lines of formal organization may seem tantamount to an impossibility or at least an unworkable arrangement of human energies.

FOCUS ON THE PATIENT

The fact is that hospitals do have a basis of organization that cannot easily be pictured in the conventional pyramid chart of organization, but that does minimize many of the apparent complexities of administrative and medical relationships when patient care is required. In time of serious patient need, hospitals act to provide the care needed and the surface appearance of administrative complexity disappears. The focus of organization becomes the patient. The needs of the patient govern the behavior of both the medical and the hospital staff, and an apparently complex organization structure acts with speed to meet the emergency.

When the ambulance arrives at the door of the accident room with the child who has been hurt at an intersection three blocks away, all strains and frictions between departments disappear.

In a sense, however, the need of the patient in critical condition is a form of adrenalin, a series of "situations" that brings into concerted effort the energies of diverse groups working in the hospital. The goal of hospital organization should be a smooth functioning, well coordinated team even when no emergency is present.

Part of the approach may lie in abandoning some of the emphasis on traditional hospital organization, even moving away from undue emphasis on formal organization. The concept of a team approach in nursing service represents one example of a new approach in establishing working relationships among hospital employes.

The need remains to clarify hospital organization structure so that at least the administrators, the assistant administrators, the department heads, and subordinate supervisors may understand the framework of formal organization within which they work, and may enjoy the personal feeling of support and security that evolves when they know where they fit into the organization, and to whom they are responsible.



The head nurse's desk usually looks like this—a chaos of confusion and questions, but when there is a

PAVILION MANAGER

to answer questions and relieve the head nurse of routine nonprofessional duties it looks like this



ANN J. DENNISON
New York City

IN JULY of 1948 a nursing service position, new in scope and experimental in nature, was established at New York Hospital, New York City. It was to be filled by a nonnurse who would function as an assistant to the head nurse and be called an assistant pavilion manager. This position was designed to reduce the number of nonnursing tasks that fall to the responsibility of the head nurse to a greater degree than had been accomplished by the introduction of the floor clerk into the nursing unit. The simplest way to explain this new worker's functions is to take you through a typical day.

At 8:30 a.m. the assistant pavilion manager reports on duty to the head nurse of a 37 bed floor, already bustling with activity. The first activity usually is making out a work list of patient traffic. It includes all those patients who are scheduled to go to the operating room, x-ray, basal metabolism, physical therapy, occupational therapy, or medical rounds. She notes which patients must have tests, and what laboratory specimens need to be collected. It is then her responsibility to be sure that these "orders" are all carried out. The patients have to be in the right places at the right times, either with breakfast or without it as the situation demands.

With these traffic situations in mind, she begins to check the sterile and bacteriological supplies and to make out requisitions to cover the following day's needs. She also supervises the attendant who is assembling the blood chemistries which must go to the laboratory. Are they all there? When the blood specimens are prepared, she assembles any other specimens that are ready and requests the attendant to take them to the laboratories.

By this time the x-ray department might telephone that it is ready for five or six patients. The assistant pavilion manager notifies the nurse in charge of each nursing team as to which of her patients have been called for, and an auxiliary worker is assigned to get the patients ready to go—either in wheel chairs or on stretchers.

The following two hours, from about 9:30 to 11:30 a.m., are taken up with a variety of duties. She talks to all patients being discharged, checking their clinic appointments. She sees that the dietitian has been notified to give any necessary instructions, also that the patient has the dressings, equipment or prescriptions that may have been ordered. Another activity is the inspection of operative and treatment permits for signatures. If supplies are being delivered from the previous week's orders they are checked and put away. A patient returning from x-ray is hungry and the assistant pavilion manager assigns a worker to get his breakfast. Another patient has to go for a basal metabolism rate; another auxiliary worker must be sent with her. A call from the operating room says that it is ready for Mrs. B. who is having a leg amputated. Is her amputation permit as well as her operative permit signed? Is the oxygen tent ordered for the patient having a pneumonectomy?

During the morning the admitting office sends up one or two new admissions. The assistant pavilion manager assigns them to beds according to the medical or nursing policy of the floor. She tells them her name and the names of their doctor and head nurse. She explains floor customs, points out the bathroom, intro-

duces them to their neighbors, and answers their nonmedical questions.

By 11:30 a.m. there is usually a lull in floor activity. This gives the assistant pavilion manager time to sign the doctors' orders that pertain to her work, *i.e.* x-rays, blood chemistries, specimens to the laboratories, and other diagnostic procedures, as they are completed. She starts an outline form for the 5 p.m. report to facilitate its completion by the charge nurse in the afternoon.

After her lunch hour she relieves the floor clerk at the telephone during her lunch period. Between telephone calls she checks medication orders to determine the quantity of perishable drugs that will be needed the next day and orders them.

PREPARES WEEKLY REQUISITIONS

For the remainder of the afternoon she may prepare the weekly requisitions—pharmacy, general stores and stationery. These each require more than an hour to complete and the afternoon seems the best time to reserve for doing them. Usually one is done each afternoon. The assistant pavilion manager also checks the laundry supply, and sees that floor equipment is in good working order. When the sink drain is clogged, she calls the plumber. She keeps an eye on the budget and tries to cut down on unwarranted expenses.

If the auxiliary workers are not busy with their team assignments, she checks their work schedules with them to see that they are completed. Above all, she answers questions from many sources. All day long there is a steady procession of doctors, patients, nurses, nurse's aides, and visitors to and from the unit, asking questions. Has Mrs. W. had her gall bladder series? May Mrs. S. have a drink of water? Is x-ray finished with Mr. F.? Is Mr. L's special medication on the floor yet? I can't find Mr. Wander, do you know where he is? Where are the tongue depressors kept? All these questions are ordinarily asked the head nurse by the parade of workers. With an assistant pavilion manager available, the head nurse can be spared most of these interruptions. To be sure, if the question is a nursing one, the charge nurse has to be consulted, but most of the queries are relatively simple to answer. Even though the assistant pavilion manager's activities are carried out in a medical environment, a nonnursing person can soon learn to perform them satisfactorily. Inasmuch as the care of the patient is the head nurse's responsibility, all of the assistant pavilion manager's duties are ultimately the head nurse's obligations also. It saves much of the head nurse's valuable time, however, if she can delegate her more routine administrative functions to an assistant pavilion manager. In addition, she can reserve her assistant head nurse for aid in resolving the professional responsibilities of student teaching, on-the-job training for auxiliary workers, and general supervision of patient care.

What are the problems involved in establishing the position? No matter what the institutional setting, the introduction of a new position into the organizational pattern may cause problems. One of the biggest in this situation is getting the assistant pavilion manager accepted by her co-workers.

If the assistant pavilion manager is going to work effectively, she must have the cooperation of the nursing staff and the auxiliary workers. The problem of not being accepted may arise when the assistant pavilion manager first comes to the floor, before the staff has had a chance to "get acquainted" and before she has an opportunity to demonstrate whether or not she is deserving of respect.

There are several ways to help the assistant pavilion manager achieve temporary prestige, until she earns a more stable kind. In the beginning, the head nurse can announce to the floor personnel that a new staff member is coming. She can explain the assistant pavilion manager's job and tell the nurses that the position compares with that of the assistant head nurse in matters concerning floor administration. Professionally, the assistant pavilion manager may know less than a young student nurse, but she still must be given status in the area in which she will be responsible.

The support of the head nurse is all important. If she accepts the assistant pavilion manager and makes it obvious to the staff that she has, half of the battle is won. On the other hand, if she indicates lack of faith in the value of the position, the assistant pavilion manager is all but lost. The nurses may tend to be uncooperative and the auxiliary workers will probably ignore her directions. The head nurse's attitude sets the pattern for the staff so her acceptance goes a long way toward promoting theirs.

Interestingly, and I suppose naturally enough, this status problem is not acute with the student nurses. This younger generation of nurses has been professionally "raised" with many more auxiliary workers in its environment and readily accepts them as part of the team.

Something of a problem exists in determining what the employment requirements for the position should be. This job requires a high school education as a minimum and high school Latin, chemistry and biology are a good foundation. College courses in physiology, chemistry, psychology and sociology are all to the good. Experience in general office work would prove valuable. Actual training is on an in-service basis. The salary should be commensurate with the worker's preparation, ability and the responsibilities to be assumed. When employing nurses a hospital's principal competition in the labor market is from other hospitals or health institutions which usually pay comparable salaries. In hiring a nonprofessional person, however, the hospital is faced with competition from a much wider range of potential employers who may be able to offer higher salaries, especially to a college-trained person. At present in this hospital the salary scale for the assistant pavilion manager ranges between that of the staff nurse and assistant head nurse.

NOT ALL HOSPITALS NEED THEM

All hospitals do not need assistant pavilion managers. In considering the position, the degree of departmental specialization of the hospital is a factor to be weighed. A large general hospital has a complex organization, and systems of communication and effectuation of procedures are difficult. The problems that arise are concomitants of large scale organization and may not be as prevalent in smaller institutions. It is possible to see, however, that in addition to relieving the head nurse, the assistant pavilion manager, in doing all of the ordering and in handling the patient traffic, fulfills a liaison function between the floor and the various hospital service departments. Perhaps this will aid in developing closer working relationships and will foster interdepartmental harmony. Perhaps hospital administrators, examining their organizational patterns, might establish such a position so that nurses can be "saved" rather than "expended."

Clinical Photography Focuses on Teaching

a small hospital finds photography a quick and effective method of instilling a more scientific spirit in the medical staff

WILLIAM A. KOZMA
Administrator
Long Beach Memorial Hospital
Long Beach, L.I.

CLINICAL photography has been an important adjunct to teaching and research in large hospitals and universities for many years. It has, like all advances in medical science, found its way into the small hospital. Here, too, it has a definite place in modern technic.

Southside Hospital, Bay Shore, N. Y., established a division of clinical photography three years ago on the recommendation of the medical staff's committee on clinical research. The latter group was formed in an effort to minimize the time usually required for medical progress to go from the large teaching hospital to the typical community hospital. This group, in its comparatively brief existence, has instilled a more scientific spirit in the medical staff and has been instrumental in keeping the staff up to the minute on new procedures and technics in the field of medicine.

RECORDS ALL INTERESTING CASES

It was found in investigating recent advances in medicine, that photography is a quick and effective way to bring these advances to a large group. From this phase the group advanced to taking pictures of interesting cases relative to new procedures for clinical conferences, and finally to an active division that photographs all interesting cases for future research, clinical writing, and clinical teaching.

Clinical photography is an important aid in fulfilling the committee's responsibilities. The value of photography as a teaching aid has been an accepted fact for many years. Further value lies in the ability to picture a given situation and to preserve it in its natural color for research. The photograph eliminates endless description which can be too easily misinterpreted by some members of any group.

The division functions as a part of the laboratory, with the responsibility for taking photographs invested completely in the medical staff. Four major classifications of photographs were established with groups of physicians assigned to each classification on a rotation basis.

1. Surgical procedures: Still and motion pictures taken in the operating room.

2. Anatomical: Still-life photographs of any external portion of the human anatomy and body cavities.

3. Radiologic: Photographs of x-ray plates and of those patients under x-ray therapy for external malignancies.

4. Pathological specimens: Photographs of postoperative specimens referred to the pathologist for study.

The system used requires a minimum of time from any hospital employe. Physicians requesting photographs complete a request form and submit it to the laboratory. Here it is classified and passed on to the man on call for photography for that day. Usually the attending physician on the case arranges to be on hand when the photograph is taken, or informs his

REQUEST FOR PHOTOGRAPHY

NAME _____ AGE _____ SEX _____ COLOR _____ HOSP. NO. _____
WARD OR ROOM _____
DATE REQUESTED _____
PHYSICIAN _____
CLINICAL HISTORY _____

CLINICAL DIAGNOSIS _____

ANATOMICAL VIEWS REQUESTED (RIGHT LATERAL, LEFT LATERAL, FULL FACE, CHEST, ETC.) _____

ACCESSION NUMBER _____ DATE TAKEN _____
NUMBER OF EXPOSURES TAKEN _____
DISTRIBUTION OF PICTURES
TO DOCTOR _____ NUMBER _____ CHARGE _____ PAID _____
TO HOSPITAL FILE _____

Mr. Kozma was formerly assistant administrator of Southside Hospital, Bay Shore, N. Y.

patient in advance of the photographs to be taken.

Actually, elaborate equipment is not necessary. Any camera with a color corrected lens, a good light source, and a leading make of color film will give good results. We are fortunate in having received a research camera as a donation. It is a completely automatic mechanism which holds all the photographic factors constant at all times, thereby minimizing completely the element of human error. The camera is designed to photograph all surface areas and all cavities of the human body. It is simply and speedily operated, even by inexperienced persons, because all features are automatic. Focusing applicators are provided to adjust properly for range to any area being photographed. With such an automatic camera one easily obtains a standard and can follow the progress with assurance that the only variation resulting will be that in the subject.

A photographic file is maintained, and all photographs are arranged alphabetically with a cross index as to pathology. Duplicates for physicians' personal use are easily available and originals are loaned as needed for research, conference, or clinical writing.

50 CENTS FOR EACH PHOTOGRAPH

We keep the division self-sustaining by making a charge of 50 cents for each photograph taken. This charge is made to the attending physician requesting the photograph. The actual cost for each photograph is about 21 cents which includes processing. The surplus is used to purchase new items for the division, to follow more interesting cases for conference work, and to purchase motion picture film for surgical studies.

The success of clinical photography at Southside Hospital is shown by the keen interest of our medical staff. Photographs are used in many clinical conferences, and are used to show apprehensive patients the "before and after" of like cases to build up their morale.

Recently a group of these photographs was used at an international conference in Europe. Another group is scheduled for showing at a national conference in the future. Future plans include the production of a motion picture on surgical approaches to the heart in cardiac arrest.

The adoption of clinical photography has led to a definite interest in more rapid insight on new procedures. It has promoted more interest in clinical conferences, and places our small hospital more nearly on a level with the large teaching hospital. The entire program of the committee on clinical research is leading to a concrete teaching program of the staff and the adoption of an intern training program.

Tornado in Texas

showed need for a disaster plan

JULIAN H. PACE
Administrator, Hillcrest Memorial, Waco, Tex.

WACO, TEX.—At 4:35 in the afternoon, which is the time the business section of Waco is most crowded, a tornado tore through the center of the town, leaving 113 persons dead, 300 families homeless, 503 persons injured.

Hillcrest Memorial Hospital is located in the northwest edge of town and was not at all damaged. In fact, we did not know a cyclone had hit the main part of town until after the patients started arriving. At 5:45 a car came into the ambulance drive with two men dazed and bleeding from injuries received in the collapse of a barn in the east part of town. These and the next few patients we received were handled as routine emergencies. Soon the patients started coming so fast that we realized some major disaster must have happened. Neither the patients nor those with them at first could give much information about the extent of the storm damage. Within 30 minutes from the time the first patients arrived at the hospital our lobby and hallways were crowded with people frantically searching for loved ones, other people trying to find out what had happened, and our emergency room was crowded.

While we do not have a complete disaster plan worked out, we have been studying several plans recently so that our doctors and key personnel were somewhat familiar with many things that should be done at a time like this.

A first aid and admitting station was set up in our doctors' lounge, which is at the right of the emergency door, where the patients could be screened and sent to special emergency teams which had been formed. At the same time the patients were being given first aid and screened, personnel from the office had responsibility of interviewing each patient, determining his name, address and whether or not he had had tetanus or other medications before coming to the hospital. This information was put on a tag and fastened to the patient. On the left side of the emergency door in the medical records room a morgue was set up.

A few of the doctors in town knew of the disaster immediately; however, it happened at a time when a number of them were making their evening rounds and were at the hospital or came in soon after patients started arriving.

A public information office was established. It was the duty of this office to notify relatives of the patients admitted and to give out information to the press and other disaster agencies.

We try to maintain a good supply of materials on hand at all times to take care of any reasonable number of emergencies; however, when our purchasing agent realized the nature of the disaster he immediately called Dallas, placing emergency orders for plasma, serum and other supplies which might have been needed in a large quantity. Soon the news of the disaster spread throughout the city and all of our personnel made their services available immediately, and many other people volunteered their services should they be needed.

During the evening and early morning 125 patients were treated and released and 40 patients were put to bed.

We were very fortunate in that our public utilities were not disrupted with the exception of a short time that the telephones were out. During this time outside communication could be carried on by the local police and highway patrol short-wave system.

Another respect in which the hospital was very fortunate was that we had just completed the remodeling of an entire division of the hospital and had it opened for public inspection on the 10th and did not plan to start putting patients in it until the 15th. By using this division we were more readily able to accommodate the disaster victims.

The Puzzle of the Paid Physicians

While the medical profession struggles to preserve the private practice system, the number of paid physicians continues to increase, and Mr. Davis wants to know why

MICHAEL M. DAVIS
Committee for the Nation's Health
Washington, D.C.

IN THE course of preparing a book, "Medical Care for Tomorrow," to be published by Harpers, I have been compelled to review a lot of statistics. Dull as most of them are, I have found one batch full of interest and puzzlement. During the last 20 years, while the organized medical profession has been struggling its hardest to preserve the free enterprise of private practice, the proportion of doctors who are employed on full-time salary and are not in private practice has been steadily mounting.

I present figures fished out of American Medical Association and government sources. It may surprise readers of The MODERN HOSPITAL—it certainly surprised me—that in 1949, the year of the last thorough study, more than one-third of all the active medical graduates in the United States were not working for themselves but were on salary. They were employed on full time by other persons or organizations, like the great majority of us. In more detail, the figures in round numbers are:

Total physicians in 1949 (As recorded in A.M.A. Directory of 1950)	201,000
Retired or out of any medical work	10,000
Total of active physicians, 1949	191,000

Of these 191,000, 124,000 were independent practitioners, working as self-employed individuals. It might be added that 11,000 of these were working in partnerships.

A not exactly known but certainly appreciable number of these physicians derived income from a salary for part time, or from payments on a time basis for work in a clinic or other organization.

Sixty-seven thousand worked for a salary as their exclusive or major source of income. This group divided thus: 35,600 were civilian physicians, other than residents or interns;[1] 24,750 were residents or interns; 7000 were in the armed forces.

In sum, only 124,000 physicians were engaged in independent private practice in 1949, while 67,000 physicians were on full-time salary. The proportion of independent private practitioners was 65 per cent; of full-time salaried physicians, 35 per cent. In 1953, the armed forces have about 12,000 physicians, instead of 7000 as in 1949.

These figures get an edge when we compare them with 1940, a year for which statistics are also available from the same source. In 1940 the proportion of full-time salaried physicians was 22 per cent. It will be noted that there is an increase of more than 50 per cent from 1940 to 1949.

We may also make a comparison with 1929, when a careful study of doctors' incomes was made under the auspices of the Committee on the Costs of Medical Care.[2] In 1929 the proportion of full-time salaried doctors, including interns, was between 16 and 17 per cent. It will be observed that the rate of growth in salaried doctors during the period 1929-40 was less than during the nine years between 1940 and 1949.

These figures represent the *total medical manpower* available to the nation. Some persons will wish to include in such comparisons only the physicians who are engaged in civilian work and who are not residents or interns. If we omit the physicians in the armed forces, the interns and the residents, numbering altogether 31,750 in 1949, there remain 159,250 active physicians in that year. Of these, about 35,600, or 22.3 per cent, were employed by an organization on full-time salary. In 1940, the corresponding figure was 14 per cent. The increase between 1940 and 1949 is again slightly over 50 per cent.

What does this large growth in salaried physicians mean? If we look at the figures realistically, we shall see they do *not* mean that 35 per cent of the present generation of physicians have chosen full-salaried service as a career. All young medical school graduates go through a period of such service as interns and a large proportion as residents. Many have an immediately following period of salaried work in the armed forces. A certain number start their subsequent life as full-time salaried assistants to older physicians, or to groups of physicians. We do not know how many of these young doctors later become self-employed practitioners, or how many continue in full-salaried work as a career in research, clinical, teaching or administrative service in hospitals, industry or other organizations.

All we can say is: (1) at least a third of the medical manpower of the

[1] We have no statistics showing just how this 35,000 divides as between those physicians who are engaged wholly or mainly (a) in *clinical work* in hospitals, industries, clinics, private offices, educational, research institutions, or (b) in *administrative* work in hospitals, clinics, public health and other associations. From such data as are available, it is probable that the clinical and the administrative groups are about equal in numbers. Some salaried physicians function in both capacities. We do not have a classification of salaried physicians according to age groups. That would be of great interest.

[2] Leven, Maurice: The Incomes of Physicians. University of Chicago Press, p. 103.

U. S. A. is now employed, not self-employed, manpower; (2) this proportion has increased greatly during the last 20 years; (3) a substantial though at present unknown number of additional physicians of all ages are in part-time employment, *i.e.* derive appreciable income from salary in addition to private practice.

The detail sources from which the statistics are drawn are stated in a footnote following the main text of this article.[3] These sources also contain facts about the comparative incomes of employed and self-employed physicians; in fact, the impulse to the studies by the Department of Commerce and the American Medical Association was an interest in physicians' incomes. There is no space for the financial statistics here, but it may intrigue hospital people to know that roentgenologists show the largest net income among full-time salaried physicians, as compared with other specialists.

What *does* the growth of full-time salaried employment among physicians mean? Certainly the meaning is not the same to laymen as it is to physicians. Certainly the meaning will be different for physicians of diverse ages and interests. For example, what does the growth of salaried employment mean to the medical student as he begins to look ahead from his junior year? What does it mean to the resident who has acquired a wife and would like to acquire children, who will be out of his hospital next summer and can soon take his specialty board examinations?

What do the figures mean to the dean of a medical school, or to the members of the Council on Medical Education and Hospitals of the A.M.A., long concerned with planning undergraduate and postgraduate medical education? What would they mean to the doctor who is preparing his annual address as president of a state medical society? What do they mean to the administrator of a teaching hospital; to the administrator of a nonteaching hospital who has been unable to get even one intern, though his hospital is on the approved list? What do the figures mean to organizations which employ physicians—the head of an industry, or of a big labor union?

Since I got at the figures, I have been puzzling over these and similar questions for some time. I have been led to prepare this article for The MODERN HOSPITAL because I hope some of its readers will have ideas about the answers. I'd like those ideas.

[3]For 1949 and 1940, the main source of the data is the report on "Income of Physicians," published in 1951 in the United States Department of Commerce, Survey of Current Business. Reprints are obtainable from the U. S. Superintendent of Documents, price 15 cents. William Weinfeld of the Department's Office of Business Economics is the author. The statistics which appear in this article are derived from pages 10, 11, 12 and 16. The Bureau of Medical Economic Research of the A.M.A. worked closely with the Department of Commerce in collecting the information from physicians by questionnaire. There was an unprecedented return—55,000 physicians responding.

Railroad wreck proves that the

Disaster Plan Works

SISTER MARY SYLVESTRE
St. Eugene Hospital, Dillon, S.C.

DILLON, S.C.—This city has a population of 5162 and Dillon County covers 398 square miles. The city of Dillon has an organized volunteer first-aid and rescue squad and a volunteer fire department.

St. Eugene Hospital will have its tenth anniversary this coming November. The hospital is staffed by the nursing congregation of the Sisters of St. Mary, whose Motherhouse is in St. Louis, and its medical staff is composed of 10 members of both the courtesy and active staff.

If any major catastrophe were ever to hit the locality (and it did) our plan was to call upon the local chapter of the Red Cross for recruitment of nurses and workers, and to call the local National Guard for beds and bedding. So when the news of the wreck of the Atlantic Coast Line Railroad on April 20 came to us, with a prayer to God to give us a helping hand, the admitting officer got in touch with these sources.

The midnight blackness thrown over the area of Dillon and Dillon County by the disruption of the electric circuit as a result of the wreck was the first signal to the citizens who were still up and about at 11:17 p.m. The citizens of Dillon and Latta, S.C., arose to the situation and going to the scene—two miles out of Dillon—brought the first victims directly to the hospital. Within a very few minutes the radio and telephones alerted all our neighboring cities so the forces of Dillon and Latta were reinforced by ambulances, nurses, doctors and Red Cross personnel from Marion, Mullins, Bennettsville, S.C., and from Lumberton and Fayetteville, N.C.

The National Guard sent a sufficient number of blankets for the victims and it also called Shaw Field Air Base in Sumter, S.C., for cots and bedding. The president of the Medical Society of Atlanta called concerning the amount of blood needed and he then arranged with the Red Cross chapter in Charlotte, N.C., to send 50 pints of whole blood, plasma and albumin. The blood arrived by truck at the hospital within four hours. Until its arrival glucose, saline and some pints of blood on hand were used.

A furniture company of Lumberton, N.C., sent down two hospital beds and mattresses to be used during the emergency. Our hospital has 60 beds for adults and 15 bassinets. No children or infants were victims of the wreck.

The Red Cross recruited nurses to care for the injured over a period of four days. During the night of the accident every nurse in the vicinity volunteered to help. The entire citizenry of Dillon and Latta was on hand to lend assistance.

As each patient was brought to the hospital the name was taken, written on a piece of paper, and pinned to the victim. The doctor gave the medication and it was red-penciled on this same tag. Those badly injured were taken to a hospital bed or cot. Those not so badly injured were placed on the floor or lined up on chairs in the

(*Continued on Page* 136)

About People

Administrators


Waldo W. Buss

Waldo W. Buss has been named executive director of Milwaukee Sanitarium at Wauwatosa, Wis., effective June 1. After attending the University of Michigan, Mr. Buss was employed by the university in the accounting and purchasing departments. He entered the hospital field by becoming a purchasing agent of the University of Michigan Hospital at Ann Arbor in 1942, and later became associate director there. Mr. Buss is a member of the American Hospital Association and the American College of Hospital Administrators. He was active in the Michigan Hospital Association and has served two terms as chairman of the A.H.A.'s committee on purchasing, simplification and standardization.


Dr. R. J. Marcotte

Dr. R. J. Marcotte, executive director of the Pittsfield General Hospital, Pittsfield, Mass., has resigned to accept a similar position at Mount Auburn Hospital, Cambridge, Mass., where he succeeds **Dr. Albert G. Engelbach.** Dr. Engelbach, who has been administrator at Mount Auburn since 1940, is the new head of the casualty services, health and special weapons defense office, federal Civil Defense Administration, Washington, D.C. Prior to April 1944 when Dr. Marcotte went to Pittsfield, he served in various administrative capacities, including two years as assistant director at the New Haven Hospital, New Haven, Conn. He will assume his new duties August 1.

Leonard P. Goudy, secretary of the American Hospital Association's council on administrative practice, has resigned and has taken over his new position as administrator of the John C. Proctor Hospital, Peoria, Ill. Mr. Goudy, who assumed his new duties early in May, succeeded **Margaret Thornton.**


Whitelaw H. Hunt

Whitelaw H. Hunt has been named administrator of the University Hospital, Augusta, Ga. His resignation from the Cooper Hospital, Camden, N.J., where he has served since 1949, becomes effective June 1. He succeeds **Oswald Daughety.**

Dr. Eugene Walker, superintendent of Springfield Hospital at Springfield, Mass., for 22 years, has announced his retirement. **E. Hampton Decker** has been named his successor. Mr. Decker has been superintendent of Prospect Heights Hospital, Brooklyn, N.Y., since 1940. He is a graduate of Rutgers University, with a master's degree from New York University in management and personnel. Dr. Walker has been active in hospital work for the last 40 years and has contributed much to the field by his active participation in national, state and local medical and hospital organizations. He holds a life membership in the American Hospital Association, was presented an award of merit as president of the Massachusetts Hospital Association, 1938-39, and is a fellow of the American College of Hospital Administrators. He served as assistant superintendent of Massachusetts General Hospital and Massachusetts Eye and Ear Infirmary and was assistant director of the University Hospitals of Cleveland, in charge of Lakeside Hospital, from 1927 to 1931.


Robert S. Forhman

Robert S. Forhman was named assistant administrator of Knickerbocker Hospital, New York City, effective April 1. Mr. Forhman completed an administrative residency at the Hospital of the Good Shepherd of Syracuse University, Syracuse, N.Y. He is a graduate of the program in hospital administration at the University of Chicago.


Dr. J. R. McGibony

Dr. John R. McGibony has resigned as director of the Division of Medical and Hospital Resources of the Public Health Service to become professor of hospital administration and director of the program at the University of Pittsburgh, succeeding **Dr. Glidden Brooks.** Dr. McGibony, who served in the Office of Indian Affairs, U.S. Department of the Interior for 12 years, joined the Division of Hospital Facilities of the Public Health Service in 1945. He is the author of "Principles of Hospital Administration," published last fall by G. P. Putnam's Sons.

Roy A. Colwell is the new administrator of Memorial Methodist Hospital, Mattoon, Ill., effective June 15. He succeeds **Marguerite Kaelberer.**


B. G. Hanson

Bertram G. Hanson has been appointed assistant administrator of Children's Memorial Hospital, Chicago. He was purchasing agent at Augustana Hospital, Chicago, for three years. Mr. Hanson recently completed requirements for his master's degree in the hospital administration at the University of Chicago.


Herbert Abramson

Herbert Abramson has been appointed assistant director of Mount Zion Hospital, San Francisco, where he has served since August 1952 as administrative resident. Mr. Abramson received a master's degree in hospital administration from Northwestern University, after completing an administrative residency at Beth Israel Hospital, New York City.

Frank R. Shank has resigned as administrator of the Memorial Hospital of Springfield at Springfield, Ill.

(*Continued on Page* 188)

How Auxiliaries Can Keep Pace

with the hospitals and communities they serve

RHEA C. ACKERMAN
Formerly, Assistant Administrator
Morton Hospital
Taunton, Mass.

JUST as wise hospital administrators and board members have learned that the vital spirit of service must never be lost sight of—but must be paralleled by an even stronger, more efficient organization—so coworkers in the hospital auxiliaries must likewise give serious thought to long-term planning and to the development of leaders. The hospitals they are associated with are big business.

For many years the hospital auxiliaries grew like Topsy. In spite of lack of guidance from a national group or from the very hospitals they were serving, the auxiliaries accomplished amazing things. Service was their aim; sincerity was their pilot, but their course remained uncharted.

PLAN FOR THE FUTURE

Hospital administrators and board members are now giving serious thought to long-range planning. It is imperative that the members of the women's auxiliaries also focus attention on future plans in terms of years of service rather than tomorrow's benefit or next month's meeting. As important as tomorrow's tea or bazaar may be, a strengthened organization is more vitally important to the very future of the voluntary hospital than any other contribution that can possibly be made.

According to the latest figures, only 29 per cent of the hospitalization in this country is in voluntary hospitals. This is a sobering thought; this figure alone indicates the urgent need for all groups allied with hospitals to coordinate their efforts.

The charts on page 88 are submitted to focus attention on ways of developing leadership through active participation by an ever increasing number of women, thus broadening the base of support for the hospital. The magnitude of the problems ahead for voluntary hospitals requires crystal clear planning.

All officers and committee chairmen should, of course, be appointed at the time of the annual meeting and the leaders should be given a free hand to plan their programs and execute their duties, using their own ideas and initiative.

The very order of the charts is significant. Fund raising does not become the immediate and the dominant aim.

A sound public relations program is constantly strengthened when the citizens are: well informed about "their" community hospital; aware of the broad interest of the members of the hospital auxiliaries in all community health projects and disease prevention activities, and mindful of the countless hours of service the volunteers in the hospital auxiliaries give to the hospital.

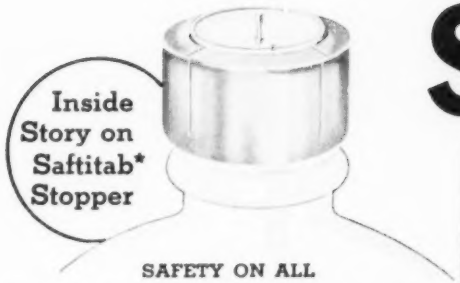
Then fund raising becomes less burdensome. The base of support of the hospital has been strengthened through participation of ever increasing numbers of women in the community. Doors and pocketbooks open more readily and check books appear more quickly when the public relations program has become a vital part of the women's auxiliary programs. Many endowments can be traced to the enthusiastic efforts of an auxiliary member. On the other hand, enemies can also be made for a hospital by a too persistent member who turns a "cold shoulder" on all other community philanthropies but constantly has her hand extended for "her" hospital. Continuous and sincere community service is the forerunner of every successful fund raising drive.

CHURCHES HAVE SAME PROBLEM

Churches and hospitals have many problems in common. It seems to me it would be wise for hospital auxiliaries to pattern their future organizations after a large church organization, which has proved to be outstandingly successful. Dr. James W. Fiefield Jr., minister of the largest Congregational church in the world, has written a small pamphlet entitled, "The Technique of Local Church Administration." Two of the important principles are the development of leadership through the organization of many small groups and active participation through singleness of responsibility: *400 members, organized in eight groups of 50 each, will be far more effective than 400 members with only 40 active members.* And everybody will be happier too!

Let's quote Dr. Fiefield. "Nonself-succession is a custom which every church properly organized should safeguard. Any losses by uprooting an individual from a position filled with honor and distinction are more than compensated for by the new strength which the principle develops. Some-churches which have failed to develop and grow could trace that failure to self-succession in office. Another closely related principle which is organizationally important is that of *single responsibility.* This means that no individual in the parish, including the

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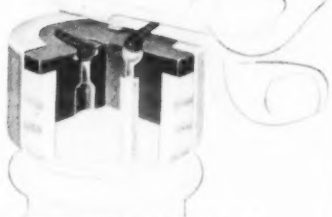
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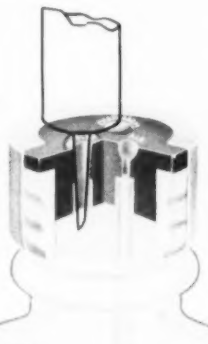


SECONDARY SAFETY SEAL

Left tab illustrates how tabs are forced into ball sockets by cap pressure.



PRIMARY SAFETY SEAL. Molded-in tab stretches a split second before it pulls out.



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For years it has been recognized that the safest closure for intravenous flasks is a stopper which is solid; that is, a stopper without holes going entirely through it. During sterilization, tremendous pressures, alternately internal and external, are built up. With a defect in the cap, liner, or bottle lip, leakage may occur. Such defects are very rare—*but very sure.* However, if a solid stopper lies under the cap, such leakage cannot occur.

Why then, have not all intravenous solutions had solid stoppers? ? The reason is that until the advent of the Saftitab Stopper, all solid stoppers, including Cutter's, were inconvenient to use and ruined expensive needles. Civilian hospital personnel just wouldn't use them. The Armed Services recognized the greater safety of a solid stopper and specifies it. They can dictate what is to be used.

We and other manufacturers recognized the greater safety of the solid stopper when we refused to sell flasks intended for such easily contaminated material as blood, plasma, and amino acids, with anything but a solid stopper.

For years we have worried about supplying intravenous solutions with closures which were "nearly" safe and have searched for open stopper convenience with solid stopper safety.

We found it—the Saftitab stopper—safer because it's solid *yet with open stopper convenience!*

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minister's wife, holds more than one office concurrently. Both of these principles are costly of effort in their first application, but presently they will have produced a wealth of leadership. If the application of these ideas involves "stepping on some toes," they had better be stepped on, rather than omit these important, strength-giving principles from the organization."

Another important factor for hospital auxiliary members to consider is a sound plan providing for the continued services of past presidents. There is a mighty force of former presidents of auxiliaries who could and would do outstanding jobs for the hospitals if a long-range program were organized. Too frequently these valuable and well informed people become inactive through no fault of their own. In fact, often their splendid contributions as president of the auxiliary would be dwarfed by future contributions they are capable of making. Let's stop now and start salvaging these important, loyal, enthusiastic women. Our expanding voluntary hospitals need them. They are well informed workers who could do commendable jobs in the field of hospital interpretation in the community. They are the logical ones to represent the hospital at the state and national meetings. It is important that they share and exchange their experiences and ideas with leaders in the hospital auxiliaries in other sections of the country and bring back stimulating reports to their own organization.

Someone has said, "Never underestimate the power of a woman." Bess Wilson, club editor of the Los Angeles *Times*, has added, "Especially if she is organized." Let's organize. Let's start thinking and talking of a 10 year plan for the hospital auxiliaries, which will parallel and supplement the 10 year plans of the hospitals they are serving.

With ever increasing service as the aim, with sincerity as the pilot, with a strengthened organization and a clearly charted course to follow, the women's auxiliaries may prove to be the saviors of the voluntary hospitals of America.

These five charts in condensed form illustrate various ways in which women's auxiliaries can broaden the base of support for the hospital. A sound public relations program built on participation in community activities makes fund raising easier.



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Conducted by Robert F. Brown, M.D.

Four Phases of the Polio Problem:

1. Michael Reese Hospital's Over-All Plan

MORRIS H. KREEGER, M.D.
Director
Michael Reese Hospital
Chicago

IF THERE is anything in the nature of consolation that can be derived from our recurring epidemics of polio, it is that their definite seasonal occurrence enables us to plan and prepare for them well in advance. This advance planning, on a group basis, is the essence of our program at Michael Reese Hospital, Chicago.

The focal point of the program is our poliomyelitis advisory committee, which consists of representatives of all departments concerned with the care and treatment of polio patients and which is charged with the responsibility of advance planning, preparation and integration of the efforts of all services and departments concerned. Representatives of the following departments serve on this advisory committee: orthopedics, pediatrics, neurology, chest, otolaryngology, anesthesia, physical medicine, urology, serum center, microbiology, nursing, social service, and the administration.

POINTS TO BE CONSIDERED

The committee meets in April or May and the first meeting covers the following items:

1. The medical director presents a report on the previous year's experience, which is freely discussed and constructively criticized by all present.

2. The representative of the serum center, who is an authority on the epidemiology and therapy of polio, discusses the expected incidence of the disease, and at this stage it is customary to have a general discussion of any new procedures, technics or equipment that have been developed during the previous year.

3. Representatives of the otolaryngology and pediatric departments discuss the problem of when to discontinue nonemergent tonsillectomies, and a definite date for such discontinuance is established.

4. The representative of the chest department reports on the status of the respirator equipment and on plans for instructing all personnel in the proper handling of the equipment.

5. The representative of the otolaryngology department reports on plans for providing emergency tracheotomy service.

6. The representative of the department of physical medicine discusses the problem of packing and other treatments that will be needed and presents his needs for equipment and personnel. There is also a discussion on indications for packing and the frequency with which this service should be provided.

7. The representative of the nursing department discusses the staffing problem and also equipment under control of the nursing department.

8. The representative of the social service department discusses problems in connection with clinic and ward cases, finances and other social considerations.

9. The group as a whole then discusses and decides, with approval of the administration, the total number of beds to be made available for children and adults, the number of acute and post-isolation beds to be provided, the location of the beds, and the length of stay of post-isolation cases. A subcommittee of staff physicians is appointed to work with the administration in implementing the rule regarding the length of stay of post-isolation cases.

The committee then adjourns, with the understanding that all decisions arrived at will be implemented unless need arises for major changes in policy, in which event the committee is to be reconvened.

HOW BEDS WERE ALLOCATED

In accordance with this established procedure the polio advisory committee met last May to prepare for the usual summer outbreak of polio, and among other things it was decided to allocate in our children's pavilion six polio beds for acutely ill children, two beds for suspect cases, and 12 beds for post-isolation cases, and in the main Michael Reese building, four polio beds for acutely ill adults.

As it turned out, last summer's epidemic was not the usual outbreak and as we progressed through June and July it became more and more apparent that, even though we were already doing more than our share in the epidemic, the number of acutely ill polio patients applying for admission whom we had to turn away because all our polio beds were filled made it necessary to consider whether we could not do even more than we were already doing.

In August, therefore, the polio ad-



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throughout

the

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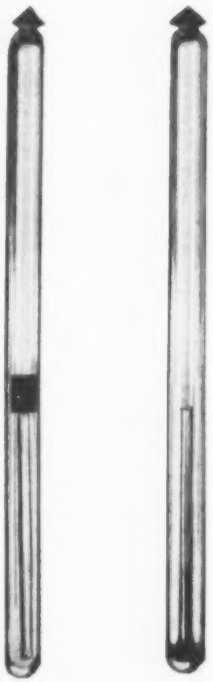
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visory committee was reconvened, and the following business was transacted:

1. The previous decisions of the committee and our subsequent experience were discussed.
2. A report was given on the current census of polio patients.
3. An evaluation was made of what might be expected for the remainder of the polio season. The outlook was definitely bad.
4. There was a discussion of the citywide hospital bed situation and available polio facilities.
5. The nursing situation was discussed.
6. The problem of equipment and personnel in the department of physical medicine was discussed.
7. The point of view of the administration was presented.

The basic decision that then had to be made was whether Michael Reese, as a private institution already doing a large portion of the polio work in the city, should undertake to do even more. Should the hospital ignore the fact that the vacation period had left it with a nursing shortage? Should it ignore the fact that there was a long list of patients, other than those with poliomyelitis, waiting for hospital admission? The answer of the polio advisory committee, with the concurrence of the nursing department, upon which the brunt of the additional work would fall, was emphatically that in view of the seriousness of the epidemic we should increase our polio facilities to the utmost of our ability.

As soon as this decision was reached, plans were quickly formulated for mobilizing the hospital's resources. In a few days an entire floor in the children's pavilion, with a capacity of 41 beds, was vacated of its nonpolio patients and converted to a polio floor. Electrical lines carrying alternating current were installed in every unit. A water suction pump was attached to each faucet. Screen doors were put on all rooms. An additional telephone was installed. Equipment for disinfecting stools and urine was set up in the utility room and in all patient toilet rooms. All necessary furniture, routine and emergency supplies, tracheotomy trays, respirators, linen, dishes and drugs were quickly assembled.

All polio patients already in the hospital, adult as well as children, were transferred to this floor. Of the 41 beds, 14 were designated for acutely ill children, 12 for convalescent children, nine for acutely ill adults, and six for convalescent adults. All personnel assigned to the polio work and all polio equipment and supplies were concentrated on this floor. In order quickly to obtain the necessary nursing personnel, one entire adult nursing unit in the main Michael Reese building was closed off and its nursing personnel was transferred to the polio unit in the children's pavilion.

The medical staff, with complete understanding and cooperation, readily accepted this reduction in the number of general medical and surgical beds. Medical and pediatric residents with special interest and training in polio were assigned to the polio unit. Additions were made to the team of packers from the department of physical medicine, so that there was a team of three packers for each 10 patients receiving this form of treatment. A total of 29 nursing personnel was assigned to the unit: 14 graduate nurses, seven student nurses, one practical nurse, six nurse's aides, and one student nursery maid.

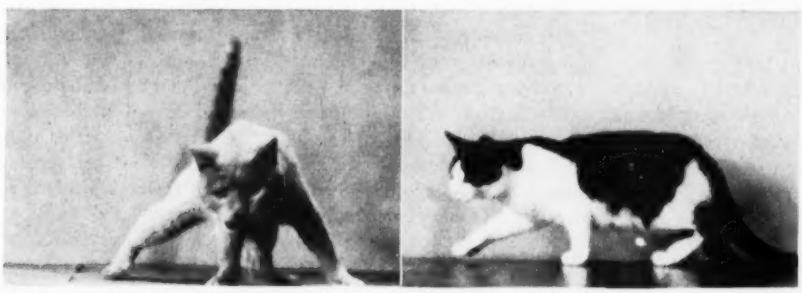
All patients in respirators and those with tracheotomies had private duty nurses. Many times these private duty nurses were general staff nurses who had already worked a full eight-hour day but who were willing to give four more hours of private duty care to these desperately ill patients. Two nurses from other hospitals in the city frequently came to Michael Reese to work on their days off, and two nurses were obtained for us by the Red Cross. The practical nurses and nurses' assistants proved of great value since they stayed with patients needing constant supervision and thus freed the graduate nurses for those tasks demanding greater skills.

By caring for adults and children on one floor, we were able to use our medical and nursing staffs, other trained personnel, and special equipment to best advantage. In a matter of days following the opening of the special polio floor, all the 41 beds were filled. During the peak period there were as many as 24 patients receiving hot pack therapy, and four patients in respirators. During the season we treated more than 140 acute and post-acute polio patients. The keys to the success of our program were advance planning and integrated teamwork.

The other three articles in this group cover medical management (p. 94), nursing problems (p. 100), physical therapy (p. 106).

New principle
in
Streptomycin Therapy

The hazard of ototoxicity is greatly reduced by combining equal parts of streptomycin sulfate and dihydrostreptomycin sulfate. The patient thus gets only *half* as much of each drug. The risk of vestibular damage (from streptomycin) and of hearing loss (from dihydrostreptomycin) is greatly reduced. Therapeutic effect is undiminished. This principle has been demonstrated in both animals and man. In patients treated for 120 days with 1 Gm. per day of the combined drugs, the incidence of neurotoxicity was practically zero.



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These new formulations embody this new principle:

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Streptomycin sulfate, Gm.	0.5	0.25	0.5	0.25
Dihydrostreptomycin sulfate, Gm.	0.5	0.25	0.5	0.25
Procaine penicillin G, units	—	300,000	300,000	400,000
Potassium penicillin G, units	—	100,000	100,000	—

(All supplied in 1 and 5 dose vials)

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2. Medical Management of Bulbar Cases

JAMES A. DOWNING, M.D.
Blank Memorial Hospital for Children
Des Moines, Iowa

AT BLANK Memorial Hospital for Children in Des Moines, Iowa, we have learned the hard way, by trial and error, about poliomyelitis. We have no university or research laboratories available, but we believe we have learned much from our clinical observations of patients from 3 months to 16 years of age, and our adaptation of equipment found necessary for their care.

Last year we had 605 polio cases with 95 bulbars. Of this 95, we did 18 tracheotomies; there were seven deaths in the tracheotomy series and three deaths among the remaining patients, making a total of 10 deaths in 605 cases.

IT TOOK TEAMWORK TO DO IT

The results achieved were accomplished through the teamwork of the pediatric staff of Blank Memorial Hospital and the ear, nose and throat personnel directed by Dr. Lee Hill, chief of the pediatric staff. As a result of our experience, I believe that at present the best therapeutic agent we have in polio is oxygen to supersaturate the nerve centers. If oxygen is good in coronaries, it certainly must be good for cerebral complications.

The time to do a tracheotomy in bulbar polio, as far as we are concerned, is determined by the clinical judgment of the pediatrician and the ear, nose and throat consultants. The anesthesia department is not consulted but may be called in to conduct manual breathing.

Both the pediatric and ear, nose and throat departments in our hospital agree that the following are indications for tracheotomy in poliomyelitis:

1. Bilateral laryngeal paralysis or spasm (Galloway) or constrictor paralysis (Pressman).

2. Pharyngeal paralysis with pooling—not controlled by nasopharyngeal suction (Fig. 1). Palatal paralysis can be demonstrated by asking the patient to say "plum pudding" and "bumble bee" and noting if nasal speech is present—as well as by direct examination of the throat.

3. Pooling with respiratory insufficiency—chest or diaphragm.

4. Any patient with pooling who needs to be put in a respirator.

5. Anoxia plus CO_2 retention, rising blood pressure, restlessness, poor cerebral response, noncooperative response. (Ask patient to count—1, 2, 3, 4 and so on—and see if he can count to 10. Determine if interruption of continuity in counting is due to cerebral depression or lack of air on account of poor chest expansion.)

When a patient comes in with bulbar polio and pooling, it is necessary to evaluate the days of febrile attack. If the respiration, carbon dioxide-oxygen exchange, and cerebration seem to be adequate, constant nasopharyngeal suction, posture treatment, oxygen and fluids should be tried.

No patient with swallowing defect should be placed in a respirator without a tracheotomy and constant nasopharyngeal suction.

TRACHEOTOMIES AVOIDED

We have avoided many tracheotomies by the following procedure. Figure 1 shows constant nasopharyngeal suction, oxygen and postural drainage (individual variations may be worked out for each patient):

(a) Constant water suction. This can be obtained from most plumbing outfits. If necessary, an electric suction pump may be used, but it burns out too easily.

(b) One gallon bottle trapped with antiseptic to prevent sewer contamination.

(c) Glass adapter to inspect adequacy of suction. If catheter (d) is in place secretion will be seen aspirated through adapter when patient closes mouth and tries to swallow. The apparatus must be inspected frequently to see that crusts do not occlude the aspirator tube. The placement of nasopharyngeal catheter must be such that when the patient tries to swallow, the secretion will be seen in the glass adapter tube.

(d) Nasopharyngeal catheter in place. Depth in the nasopharynx depends on perforations in the catheter. Plastic is preferred to rubber, as the catheter may need to be in place for weeks.

(e) Oxygen tent. Ten to 20 liters of oxygen may be needed, as there is great leakage through the mattress.

(f) 20° posture shown will need support, as the patient tends to slide headward and needs fixation (g). Nasal hemorrhage is a frequent complication of the catheter in the nose. The trauma of the catheter plus the low prothrombin time in most of our patients is the cause. Vitamin K is indicated.

NEEDS CONSTANT SUPERVISION

Constant supervision of nasopharyngeal suction is absolutely necessary. If it breaks down, there is trouble. The nasopharyngeal suction tube must be removed and cleaned, and tubing must be cleansed by drawing water through it, especially after feeding is started.

In case this nasal suction, posture and oxygen do not give relief, a tracheotomy is necessary before the patient is put in the respirator. In this instance the University of Minnesota oxygen dispenser (Fig. 2) is used, with plastic respirator collar. A tight-fitting collar is necessary. Following

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*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

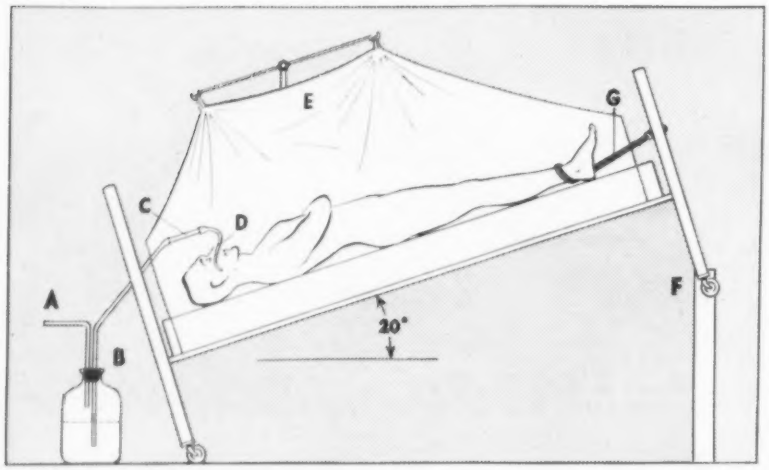


Fig. 1

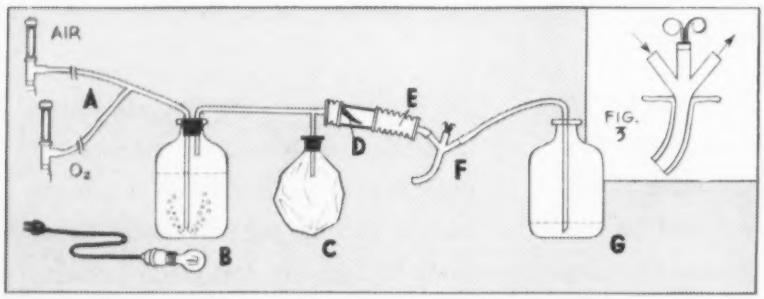


Fig. 2

Figure 1 shows constant nasopharyngeal suction, postural drainage and oxygen catheterization. For details of technic see text on page 94. Figure 2 is a diagram of the special oxygen dispensing apparatus, and Figure 3 shows the T tube developed by Dr. Downing and associates.

is a description of the oxygen dispenser apparatus (Fig. 2):

(a) Air and oxygen are on individual flow meters so a mixture can be made if desired.

(b) Gallon bottle (corked) with wetting agent, a small amount of sodium lauryl sulfate or (Tween 20) to supersaturate oxygen with water, and a 60 watt red or green light under the bottle for heat. (A white globe disturbs night care.)

Oxygen of high temperature should not be administered to patients who are febrile. A sufficient amount of water should be supplied through the oxygen apparatus so that there is no crusting of the tracheobronchial tree. The amount of water delivered to the tracheobronchial tree through the T tube (Fig. 3) depends on the temperature of the oxygen and water current. With a 60 watt globe, the temperature of the oxygen delivered to the T tube is about 86° F.

(c) Rubber anesthesia bag for reserve oxygen so when the respirator calls for oxygen a reserve is immediately available. (This can be disconnected and emptied so that excess water does not enter the trachea.)

(d) One-way flutter valve can be made from an ordinary duck call by grinding down the edge on an emery wheel and replacing vibrating reed with a piece of plastic or rubber. If necessary, a plumber's check valve, which is not as good, but workable, may be used.

(e) Large lumen anesthesia tubing from flutter valve to T tube, to keep friction down. Connections with large tubing to tracheotomy T tube should be made as short as possible.

(f) See Figure 3 for details of T tube.

(g) Expiratory bottle (not corked) contains 2 or 3 centimeters of water, depending on the size and vital capacity of patient. Plastic tubing is better than glass in all this setup, as it cannot break as easily. The rate of flow of oxygen depends on the size of the patient. An excess of oxygen is wasteful, but the expiratory bottle must bubble freely on each expiration. A clogging of the expiratory tube will cause carbon dioxide retention and trouble. We have found that about 15 centimeters of negative suction and 10 centimeters positive pressure on the respirator give the best results in most cases. The plus pressure tends to push secretions into the larger bronchi, where they can be aspirated. In cases of swallowing paralysis, nasopharyngeal suction must be continued and if it is not adequate, the foot of the respirator is elevated 20°. It is not possible to use large enough tracheal cannulas to stop aspiration of mouth secretion into the chest.

Description of T tube (Fig. 3): One arm is for oxygen or oxygen-plus-air input. One arm is for suction (corked when not in use). One arm is for the expirator and carbon dioxide exhalation bottle (not corked).*

Nursing and tube care in the tracheotomy patient: A vent in the suction line is necessary. A hole drilled in ¼-inch copper tube and inserted in the line is adequate. A catheter with cut-off end square, and softened by heat, should be put in with suction off (vent open), then pushed down as far as it will go on *each inspiration.* No damage can be done as long as the vent hole is open. When the catheter is down as far as possible, the vent should be closed, then the catheter is rotated and withdrawn. Nurses hesitate to push the catheter *down* far enough, for fear of damaging a bronchus. But the airway to the alveoli must be kept open. To aspirate the left lower lobe turn the head to the right; to aspirate the right lower lobe turn the head to the left. The inner cannula should be removed every one to two hours, cleaned with pipe cleaners and replaced, the lock secured so that crusts do not form and clog in the lower portion of the outer cannula. Immediately after tracheotomy, suction should be done every 15 to 20 minutes. The interval can be longer as secretions lessen.

*See Journal of the Iowa Medical Society, October 1950, for engineering data on tube sizes, angles, etc.

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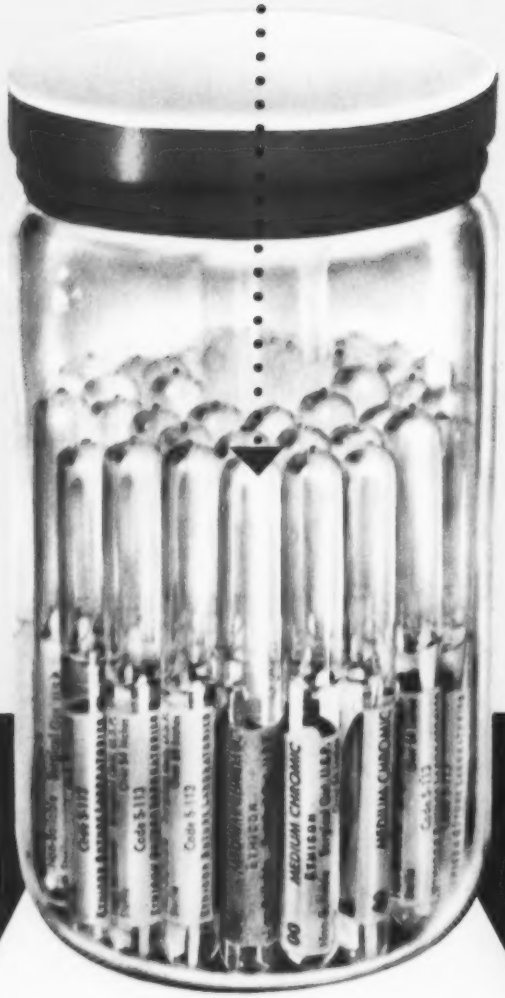
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Alexander Pope, on winning...

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Secretions are thin and profuse for the first 24 hours. Later, they become thick, but they may be profuse for several days.

Catheter care: A pan of germicidal solution should be at hand to keep spare catheters clean and a basin of water should be available to clean the solution off before the catheter is used. Water should be drawn through catheters to cleanse them of solution. Catheters should be left wet for inserting into the T tube. A clean pillowslip is useful to tuck aspirating catheter and tubing into between uses. To clean tracheotomy tubes: Soak in cold water. Scrub inside and outside of both inner and outer tubes. Remove all blood, mucus, and other material. Soak in germicide and clean thoroughly before sterilizing. In case the tube clogs, remove tube and suction and replace spare tube. Do not use too large a catheter for bronchial suction; use one that goes far down in either left or right bronchi. Several sizes should be available for choice.

Some antiseptic ointment should be used about the wound tube. T tubes of various sizes should be purchased in pairs, so that the inner cannula will fit either tube in case of a mix-up. Corks for the aspirating cannula can be easily made by bending a pipe cleaner and adding a bit of adhesive to fit the tube.

In the case of crusting, which should not occur, the trachea and bronchi can be irrigated with NaCl solution or KOH 1/10 of 1 per cent, and aspiration to loosen secretions. Tracheotomy patients must *never* be left alone. Bronchoscopy is seldom necessary if nursing care is adequate. The commonest complication of a tracheotomy in poliomyelitis is atalectasis of the right upper lobe. We believe this is caused by lack of adequate suction by catheter of the tracheal tube, poor care of the nasopharyngeal suction, and inadequate posture. The atalectasis can be relieved somewhat by aspiration with a flexible, curved aspirator tip through the tracheotomy wound. Patients ask for suction after two or three days, when secretions are allowed to accumulate through neglect.

Feeding can be started when the febrile period is over—usually from seven to 10 days. It should be done slowly, first by the drip method (40 to 60 drops per minute) of water or dilute glucose solution.

Nasopharyngeal suction must be adequate to prevent aspiration of feedings. Feedings may be gradually increased to tolerance. Relearning to swallow is the worst problem for many patients, who must be coddled and coaxed. Semisolids seem to be the best foods to start. Ripe bananas, apricots, and soft eggs are best. Liquids seem to give no grip to the weak muscles. Nasal suction is necessary when trying to reeducate the swallowing apparatus. At times patients do better in the sitting position with the tracheotomy tube out. Morale of the patient must be kept high. Only patience and perseverance can reeducate the swallowing apparatus.

When the patients' respiratory systems show evidence of improvement, much time can be saved by placing them, at increasing intervals, on the rocking bed. This not only helps in the respiratory effort by changing the pull and posture of the abdominal contents, but tends to improve the general capillary circulation.

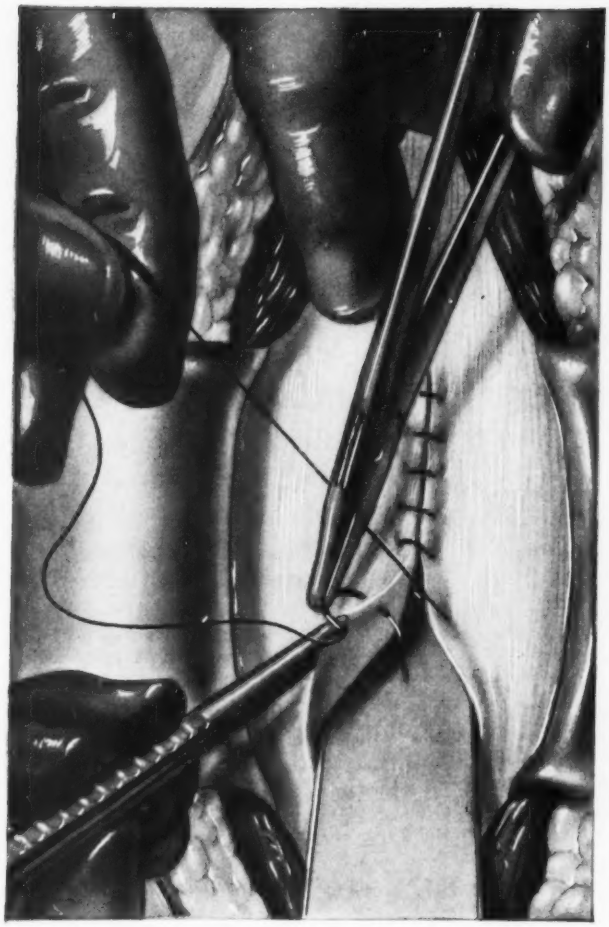
AIR SHOULD BE HUMID

After the patient has been out of the respirator for intervals of several hours and the T tube has been replaced with a plain Jackson tube, trouble begins because of the low moisture content of the air. Room humidity is usually low, especially after the heat (steam radiators) has been turned on. To mitigate the effects of dry air, we must use wet packs over the tube, or humidity apparatus. Hot steam takes the curl out of the nurses' hair, and they do not like it. Cold spray apparatus may be obtained; this leaves a deposit on furniture and furnishings but is satisfactory for hospital use.

Even after the plain tube is out and the patient is comfortable as long as he is awake, nasal suction may be necessary at night. Laryngeal function is not restored till the patient can develop expulsive cough. We have one patient who has had bilateral laryngeal paralysis since 1949.

We try to anticipate erosions on the back of the neck of respirator patients by collars and by putting on two layers of moleskin. The results are not too good. We have tried added layers of foam rubber and chamois skin, and these are not much value either. There must be better collars and we hope to find them.

Accidents should be anticipated in every possible way. It is not the big things like tracheotomy that lower



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mortality; it is the small details—like care of nasopharyngeal suction tubes, posture, oxygen, adequate suction of the tracheotomy tubes and nursing care that spell success or failure. The surgeon who does the tracheotomy is remiss in his duty if he does not personally follow through the after care of the patient, seeing that the nursing care, suction, posture, oxygen input and carbon dioxide output are adequate. No ear, nose and throat surgeon should do a tracheotomy who is not willing to do the after care.

Hospital administrators should note that the equipment described here is useful in tetanus, skull fractures, chest injuries, barbiturate poisoning and botulism, and should be available at an instant's notice for the care of these emergencies.

3. The Nurse's First Job: Establish Confidence

JACQUELYN COOK
Des Moines, Iowa

DOCTORS and hospital personnel are beginning to recognize the need for reorganization of various departments within the hospital so that polio can be adequately and effectively treated.

The nursing shortage throughout the country presents a serious problem in polio stricken districts. Nurses are called from the ranks of inactive duty, and auxiliary helpers are asked to volunteer during a polio crisis. With this supplementary personnel it is the duty of the nurses regularly employed on polio wards to teach the nursing care so essential to the patient's rapid recovery.

The publicity connected with poliomyelitis and the belief of the public that the patient is doomed to a lifetime of crippling make great demands on the nursing care during the acute stage. The first essential for the nurse in the case of polio is to win the confidence of her patient and his family. The first impression made on admission usually lasts throughout hospitalization. The patient is apprehensive and restless and has severe muscle pain; he, therefore, requires skilled nursing care not only for reassurance and comfort but also to help prevent deformities. He should be prepared for all treatments and examinations, for he cannot be expected to cooperate if he does not understand what is taking place. It is not unusual for the patient to be unreasonable in his demands and uncooperative during treatments; the nurse should understand that this is part of the illness and that as convalescence begins much of it will disappear.

The nursing personnel must be impressed with the importance of watching and reporting any changes of pulse, respiration and blood pressure. These may be the first indications of cranial involvement. When observing the rate and rhythm of respirations, the nurse should inspect for rigidity of chest and abdominal muscles or "ballooning" of the abdomen. Learning to listen for a change in the quality of the voice is important, as a nasal twang or the tendency to slur may be one of the first developments of the bulbar type of polio. When the virus is spread to the medulla the vital centers of respiration and swallowing will be affected; respirations become shallow, the patient speaks with a nasal twang and, in some instances, fluid will return through the nose and throat.

Treatment is aimed to prevent aspiration of secretions into the lungs and to maintain adequate oxygen exchange. Postural drainage is instituted immediately, and the foot of the bed is elevated to a 40 degree angle. The patient's head may be turned to one side and he is preferably placed on his abdomen. Oxygen therapy is instituted on the order of the physician and usually is administered by nasal catheter. Frequent suction of the mouth and throat may be ordered.

The use of continuous pharyngeal suction by continuous water suction has proved very successful. In this event it is no longer possible to use an oxygen catheter, and an oxygen tent is employed. To prevent cracking of the area around the mouth, petroleum jelly should be applied. Intravenous fluids of hypertonic solution may be given to reduce the cerebral edema.

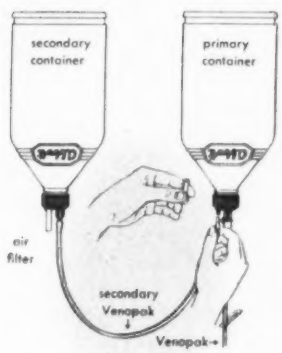
As soon as the patient is able to swallow, fluids are offered in small amounts; often a spoon is more effective than a drinking tube. As progress is made, gelatin and puréed foods are given until the patient is able to tolerate a soft diet.

The bedside nursing care of polio patients is exacting, and its success depends upon the conscientious following through by the nurse. It is essential that all patients be kept as quiet as possible. Personnel should be taught to work with a minimum of noise; bright lights and drafts should be avoided; the hands of the nurse should be warm—these are small details but are essential for the patient's comfort.

The bed should be equipped with a firm mattress and good springs. A fracture board or one made of plywood should be placed under the mattress to prevent sagging. A foot board should be placed 4 inches from the end of the mattress to help prevent pressure from the bed clothes and also to provide a firm surface against which to press the foot. The entire mattress should be protected by a waterproof material, and the bed should be made with blankets rather than with sheets, as they are more absorbent and prevent chilling. A cotton sheet may be placed under the head to prevent irritation of the face.



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It is sometimes thought best not to give baths during the acute stages as it tends to aggravate spasms. When baths are given the nurse uses a gentle sponging movement and dries the part by patting instead of rubbing.

The mouth should be kept very clean, and when a toothbrush cannot be used cotton applicators should be employed. The mouth should be rinsed with any agreeable mouth wash, preferably one that is alkaline to counteract the acidity. The nose can be kept clean with applicators moistened with liquid cleaner, after cleansing, the same medication should be left on the membranes to keep them moist.

Good body alignment should be applied as far as it is possible; much emphasis should be placed upon the fact that contractures may develop even though no paralysis exists. Frequent changes in position are essential. The patient should be turned as a unit without being twisted, and the joints should be supported to prevent stretching of the joint structures and muscle spasms.

During the acute stage of the disease, fluids, and fluids only, are liberally given; the amount should be measured and recorded. The diet should be highly nourishing as soon as the patient can tolerate it; if there are no bulbar signs most physicians feel that a normal diet may be established.

An accurate urinary output record should be kept since temporary paralysis may occur and a retention catheter will have to be inserted. Constipation may present a problem if the abdominal muscles and the diaphragm are involved, as a distended bowel may increase the spasm. A mild laxative at night, followed by a soapsuds enema in the morning, is frequently necessary.

Hot moist packs are used to relieve the pain and spasms and to help improve the circulation. If the patient is acutely ill, the packs may be ordered for the spine and chest only. When packs are being applied, the nursing personnel should be mindful of the following points: Handle the patient with extreme gentleness; maintain good body alignment; observe the patient closely; see that all the excess moisture is out of the material; avoid chilling; offer fluids, and give sodium chloride to all the patients being packed.

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While the polio bed patient requires a great deal of care, the respirator patient requires constant attention. A respirator should be in readiness at all times. It should be the duty of the engineer and electrician to check the equipment daily, and the nurse should be taught the function of each part so that she may detect any misfunction.

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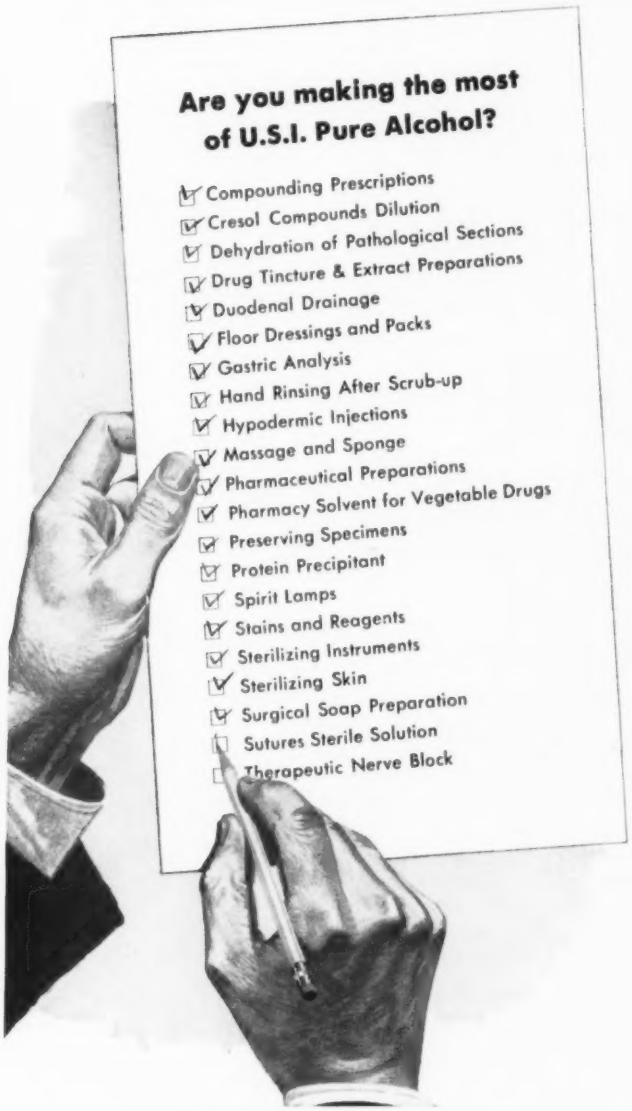
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respirator the procedure should be explained to him to lessen his apprehension. Four or five persons are required to place an adult in a respirator. Good teamwork is essential, and each member of the team must know his own task in the procedure. The patient is placed on his back in the carriage and one person stands at the head of the respirator to assist in bringing the patient's head through the collar. The movements are all done simultaneously so that there is no pulling or pushing on the body. The rate and depth of the respirations plus the pressure is checked by the doctor. The patient must be encouraged to relax and breathe with the respirator.

Usually it is possible for a patient to be removed from the respirator long enough for a bath and back care, the head being left in the collar. It is important that the skin be kept warm, dry and clean. The neck should be given special attention to prevent abrasion and abscess formation.

If there is inability to swallow, feedings are given by a Levine tube. For eating the patient is taught to swallow while the respirator is in the expiratory phase. Special effort should be made to prevent complete confidence in the respirator as the patient should begin as soon as possible to rely on himself. A portable respirator is often used as a change for a long-term respirator patient.

If the polio patient has a tracheotomy, special attention must be given to it. A continuous pharyngeal suction is sometimes used and, if not, a portable one should be on hand and ready for use, as the mouth, nose and trachea must be suctioned frequently to prevent aspiration.

The convalescent period of the polio patient is especially important as it is the preparation of the patient for his return to the outside world. In addition to the physical rehabilitation often required of the patient, the psychological rehabilitation also is of great importance. To aid in this rehabilitation the ward should be as homelike as possible.

A good plan for nursing care requires a well equipped and well organized ward setup. In laying out a polio ward, the first essential is to plan with expansion in mind, so that polio patients can be adequately cared for during epidemics. Postpolio patients should be kept separate from the patients in the acute stage.

It is necessary to have the nurses' station and charting desk away from the rooms so that it may be considered uncontaminated. The utility room and the examining rooms are best placed near the nurses' station and away from the rooms, both for convenience and so that they also may be "clean" rooms. Also near the nurses' station should be rooms for the critical cases, which need a great deal of watching.

There should be a large room for respirator cases. This room should be large enough to accommodate extra respirators during an epidemic. With the respirators located in one room, only one nurse is needed to give the constant care and attention necessary for respirator patients.

Patients' rooms should be well arranged over the remainder of the floor and should be large enough so that there is ample space for special equipment, such as I.V. standards and suction apparatus. These rooms should be well ventilated and properly illuminated. Each room needs a foot pedal controlled lavatory so that isolation technic can be carried out.

(*Continued on Page* 106)

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Centrally located in the ward should be a room for the storage of packing equipment and the facilities for its care and preparation. Another room should be provided as a workroom for refuse disposal and for the cleaning of utensils.

The polio ward, as any department within the hospital, should be designed to save steps and time, but it is here more than any other place in the hospital that short cuts on space cannot be made, as during a polio emergency every inch of available space is needed.

4. Make Room for Physical Therapy

it will pay dividends in terms of quicker dismissals that make more beds available

LORETTO SULLIVAN
Des Moines, Iowa

DURING a polio epidemic the polio isolation ward in the hospital is an extremely busy and crowded place: extra beds and respirators, I.V. standards, suction apparatus, packing equipment, hurrying hospital personnel, and anxious relatives are all occupying every available inch of space. Space is always a major problem; in the anxiety of trying to squeeze in another bed, the physical therapy room is likely to be forgotten. Yet, we all know the necessity of efficient and effective physical therapy in the recovery of a polio patient.

SET ASIDE SMALL ROOM

In order for the physical therapy department to give each polio patient the necessary and effective treatment, a small room should be set aside on the ward. This treatment room need not be elaborate or large. On an isolation ward the main necessity is a treatment table with a firm pad and enough room to bring in a stretcher. There should also be a small desk in which to keep muscle charts and progress reports.

To realize the value of a separate physical therapy treatment room in a polio isolation ward, one need only visualize a typical three-bed or four-bed room at the height of a polio epidemic. The scene is usually one of crowded confusion: the three or four beds may have been increased to six or eight beds; there is a continuous flow of traffic back and forth to care for the patients; at the windows there may be visitors calling encouragement to those within. To be effective, physical therapy treatment requires conditions impossible to manage in this atmosphere; reeducation of paralyzed muscles requires the utmost concentration on the part of the patient.

One of the most important factors in the treatment of polio is teamwork among all personnel coming in contact with the patients. A therapy room on the ward means that the therapist is available at all times for conferences among doctors, nurses, packing aides and the families. It is of particular importance that the therapist be on hand when the doctors make their rounds to discuss the condition and treatment of the patient, as well as to do muscle tests and evaluations as they are requested.

One of the postpolio complications which occurs frequently is spinal curvature. There are several causes for this condition: imbalance of muscles caused by weakness or paralysis; stiffness in one or more muscle groups; and a third cause is poor posture in bed. This third cause aggravates the first two and increases the resulting deformity. Curvature can be kept to a minimum and in many cases avoided entirely by constant supervision of the bed posture of each patient. The amount of time required to accomplish this important training can be measured in minutes when the therapist is present on the ward at all times and is making regular rounds among her patients.

It is desirable to treat a polio patient in short periods and as often as possible. During an epidemic this cannot be carried out when the therapist has great distances to run between her department and patients; with the therapist on the ward, there is time for more frequent treatment and closer observation.

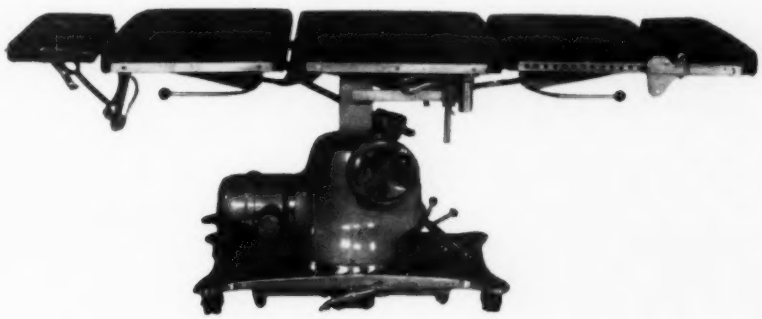
STIMULATE HIS INTEREST

Along with the medical treatment of the polio patient it is necessary to stimulate the patient's interest in life, which is a definite asset toward a speedy recovery. Bringing the patient to the therapy room adds interest and is a morale booster; this stimulates the concentration and hard work necessary for rehabilitation.

If the question arises as to the advisability of utilizing precious space for a treatment room at a time when hospital beds are at a premium, the best answer is that with more frequent and efficient treatment, patients will be dismissed quicker, thus providing more beds in the long run.

Greater Flexibility...



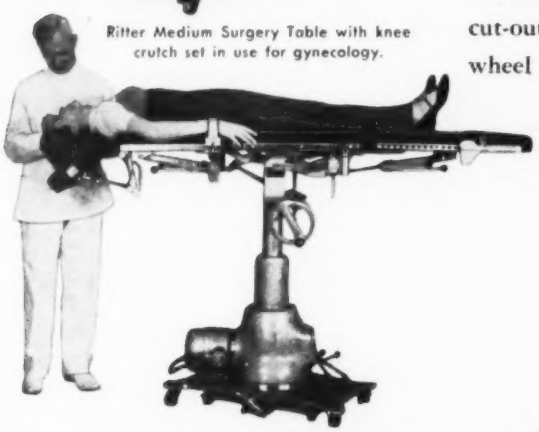


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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Succinylcholine —

a short-acting skeletal muscle relaxant

DURING the last 10 years standardized curare preparations and synthetic substances with a neuromuscular blocking action have obtained a widespread clinical use as muscle relaxants. In addition to tubocurarine and the dimethyl ether of tubocurarine, the substances most extensively used have been tri(diethylaminoethoxy)benzene triethiodide (Flaxedil®) and decamethylene-bistrimethylammonium bromide (Decamethonium). All these compounds have a relatively long duration of action (15 to 40 minutes) and are, therefore, to some extent unsuitable when only short-term or easily regulated muscular relaxation is required. A muscular relaxant which combines a lack of toxic effects with a brief, easily regulated action has therefore been a desideratum.

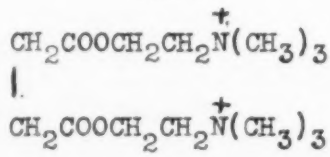
HISTORY

Succinylcholine was described for the first time in 1906 by Hunt and Taveau who studied its effect on the blood pressure but failed to observe the neuromuscular block that it produced. In 1949 Bovet et al. and, independently, Phillips were the first to demonstrate its potent, short lasting blocking effect on neuromuscular transmission. Further pharmacological investigations were made by Castillo and de Beer, Ginzel et al. and Thesleff.

CHEMISTRY

Succinylcholine is a synthetic quaternary ammonium base (Fig. 1) commercially available as the iodide or chloride salt. The brief action of the substance is due to the fact that it is hydrolyzed by the pseudocholinesterase of the plasma. It also undergoes rapid spontaneous hydrolysis in alkaline solution. The end products of hydrolysis are succinic acid and two molecules of choline; both, succinic acid and choline, are normally occurring metabolites. The enzymatic hydrolysis of succinylcholine proceeds stepwise; initially only one of the ester linkages is attacked. The formed mono-ester is hydrolyzed at a slower rate than is succinylcholine. However, this seems to be of no great clinical importance since succinylmonocholine has a neuromuscular blocking activity of only 1/20 of that of succinylcholine.

FIG. 1



PHARMACOLOGY

Mode of action: In order to understand the action of succinylcholine on the neuromuscular junction it is necessary to be acquainted with the present conceptions of neuromuscular transmission and different forms of neuromuscular block.

The investigations of Dale, Feldberg and Vogt in 1936 led to the now generally accepted view that stimulation of a motor nerve results in the liberation of acetylcholine, or of a closely related substance, at the nerve-ending. This substance causes a rapid depolarization of the muscle end-plate (end-plate potential) which, in turn, gives rise to a propagated spike potential causing the muscular contraction.

Tubocurarine-like substances interfere with this physiological process by decreasing the sensitivity of the muscle end-plate to the depolarizing action of acetylcholine. For this reason, the acetylcholine liberated at the nerve-ending does not evoke an end-plate potential of sufficient magnitude to excite the muscle fibers. Tubocurarine thus produces a neuromuscular block by preventing depolarization.

Another type of neuromuscular block is that obtained by excessive doses of acetylcholine or by substances which by themselves cause a persistent depolarization of the muscle end-plate. When the muscle end-plate is completely depolarized, no impulse can reach the muscle fibers and a neuromuscular block has developed. Decamethonium and succinylcholine produce in most species a persistent depolarization of the end-plate and are therefore classified as depolarizing muscle relaxants.

A neuromuscular block caused by depolarization differs in certain characteristic respects from a block produced by tubocurarine. Thus, cholinesterase-inhibitors have no antagonistic action and may intensify the neuromuscular block. Owing to the mode of action on neuromuscular transmission, tubocurarine and depolarizing substances show a mutual antagonism.



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Another characteristic feature of a depolarizing substance is that its intravenous or intra-arterial injection gives rise to transient stimulation of some groups of muscle fibers (fasciculations), which precede the neuromuscular block.

Neuromuscular block: The duration of the neuromuscular block caused by succinylcholine is generally short lasting but shows considerable species variations.

On intravenous injection in man succinylcholine has a very rapid onset of action; the maximal effect is obtained approximately within one circulation time (<60 sec.).

With doses causing complete muscular relaxation the duration of neuromuscular block varies between three and 10 minutes. After onset of recovery the muscle strength returns rapidly and is completely restored within a few minutes. In contrast to the action of other muscle relaxants, repeated administration of succinylcholine does not give rise to cumulation or tachyphylaxis.

The course of paralysis shows the same characteristic pattern as that produced by other muscle relaxants, *i.e.* the external eye muscles are the first to be affected, followed by the muscles of the pharynx, the muscles of the neck and the muscles of the extremities. The diaphragmatic muscle is the last one to be paralyzed.

The ratio of the dose of succinylcholine that paralyzes the peripheral skeletal muscles to the dose that paralyzes the respiratory muscles or "the respiratory sparing effect" of the drug is 1:2 or about the same as that of tubocurarine.

Since succinylcholine is broken down by cholinesterases its action can be *prolonged* by anticholinesterase drugs. It is therefore especially important to note that neostigmine, physostigmine and Tensilon®, which are used as antidotes to tubocurarine, are not antidotes to succinylcholine but, on the contrary, will potentiate and prolong its effect. Ether anesthesia, which markedly prolongs and potentiates the blocking action of tubocurarine, does not influence the neuromuscular blocking effect of succinylcholine.

Other systemic effects: In clinically employed doses, succinylcholine, unlike tubocurarine, does not interfere with the transmission in autonomic ganglia, nor does it liberate histamine in the tissues. The tonus of smooth muscles is not altered by succinylcholine. Its effect, per se, on blood pressure and heart rate is negligible.

Like other muscle relaxants succinylcholine, in therapeutic doses, does not pass "the placental barrier."

The effects of muscle relaxants on the central nervous system have been the subject of some controversy. No clear-cut evidence for a direct action has been produced although some investigators point out that large doses of all muscle relaxants, including succinylcholine, may produce inhibition of the respiratory center. However, succinylcholine under no circumstances produces anesthesia or loss of consciousness.

The depolarizing action of succinylcholine has been shown to activate the muscle spindles to a marked extent. This activation occurs with subparalytic doses and interferes with the spindles' normal function of regulating muscular tonus. Subparalytic doses of succinylcholine may therefore produce ataxia and in some cases loss of monosynaptic spinal reflexes.

CLINICAL USE

In anesthesia: Succinylcholine is a particularly suitable muscle relaxant when only a brief effect is required, *e.g.* for endotracheal intubation, bronchoscopy, abdominal closure and for reduction of a fracture or dislocation. In these cases succinylcholine is given as a single rapid intravenous injection. The recommended dosage is approximately as follows (the dosages given apply for succinylcholine iodide; if the chloride salt is used the dosage should be two-thirds that of the iodide):

0.1-0.2 mg./kg. of body weight results in satisfactory relaxation of the peripheral skeletal muscles from one to three minutes. In the majority of cases, the respiration is unaffected.

0.3-0.4 mg./kg. of body weight produces complete relaxation of the peripheral skeletal muscles for from three to five minutes and, as a rule, depresses the respiration.

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Photo No. 1—Inhalation Completed. Photo No. 2—Exhalation Started. Photo No. 3—Exhalation Completed. Respiratory cycle is from Photo No. 1 to Photo No. 3 and back to Photo No. 1. Speed and angle of oscillation is regulated by controls on instrument attached to base of bed.



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0.5-1.0 mg./kg. of body weight causes complete relaxation of all the voluntary muscles for from five to 10 minutes and necessitates artificial respiration for part of this time.

Succinylcholine can be used by infusion during major surgery to produce a long lasting and easily regulated muscular relaxation. It is given as an intravenous drip infusion at a dose of approximately 0.05 mg./kg. body weight per minute. This is obtained by infusing an 0.1-0.3 per cent solution in sterile physiological saline or in glucose solution at a rate of 60 to 20 drops per minute. This mode of administration has proved easy to handle, and no difficulties are encountered in obtaining the desired degree of muscular relaxation.

In electroshock therapy: The commonest complication associated with electroshock therapy is fracture, particularly of the vertebrae. The introduction of muscle relaxants as a preventive measure has considerably reduced the incidence of fractures. The brief but potent effect of succinylcholine makes it eminently suitable for application in electroshock therapy. Succinylcholine is administered in a dose of 0.2-0.3 mg./kg. body weight together with a small amount of a short acting barbiturate. With this dose, the convulsions are only slight in the majority of cases and no special arrangements are required for fixation or positioning of the patient. When the convulsions have ceased spontaneous respiration occurs almost immediately and no further supervision is thereafter necessary.

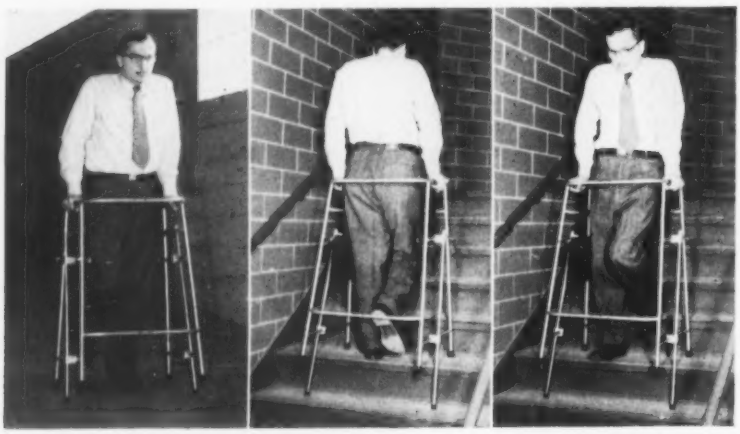
In partients suffering from cardiovascular disturbances the stress caused by electroshock treatment can be greatly diminished if the convulsions are completely abolished by the administration of large doses of succinylcholine (0.5-1.0 mg./kg.).

CONTRAINDICATIONS AND CAUTIONS

The use of succinylcholine is contraindicated when the patient has received anticholinesterase drugs, or if there are indications that the patient has been exposed to such chemicals. Succinylcholine should be used with caution when the patient shows marked malnutrition or is dehydrated inasmuch as a low plasma cholinesterase level can be expected in those conditions. Large amounts of procaine will also retard the hydrolysis of succinylcholine.

In this connection it should be pointed out that the use of succinylcholine is *not* contraindicated in patients suffering from myasthenia gravis. The neuromuscular blocking action of succinylcholine is not prolonged or potentiated in this disease in contrast to the marked potentiation of paralyses produced by tubocurarine-like drugs. In fact, it has been demonstrated that a depolarizing substance will, in small doses, to a limited extent improve the muscular fatigue in myasthenia gravis.

Since succinylcholine blocks neuromuscular transmission it may produce respiratory arrest. Therefore, it should be used only by those skilled in the administration of controlled respiration and endotracheal intubation, and only when facilities for these procedures and for the administration of oxygen are immediately available. A few cases have been reported in which prolonged respiratory apnea followed the use of the succinylcholine. These complications have occurred after large single doses and have been attributed to an inhibition of the respiratory center.—STEPHEN THESLEFF, M.D.



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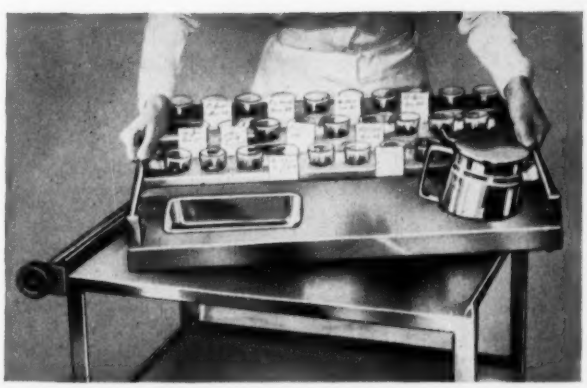
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Conducted by Mary P. Huddleson

Centralized or Decentralized Service?

Faulkner Hospital combines them for greater efficiency and patient satisfaction

MARIE-CLARE ROWBOTHAM
Administrative Dietitian
Faulkner Hospital
Jamaica Plain, Boston

THE type of food service in use at the Faulkner Hospital, Jamaica Plain, Boston, is a modification, as well as a combination, of centralized and decentralized service. Each patient's plate is served in the main kitchen under the supervision of a dietitian. All special diets are served in a small special diet kitchen, under the supervision of the therapeutic dietitian, by a diet kitchen aide and student nurses during their diet therapy experience. After the special diets have been served, the diet maids move their trucks to the range unit, and the house diets are served. The house diets are served by the chef and cooks, under the supervision of the ward dietitian and the administrative dietitian. Patients, whether private or ward, or whether on therapeutic or house diet, receive a selective menu for each meal.

Faulkner Hospital is a 144 bed, private, nonprofit institution with medical, surgical and obstetrical services—each service located in its own wing. There is a total of seven floors: three surgical, two medical, two obstetrical. Each floor has its own ward kitchen equipped with a refrigerator, stove, cabinets, sink and dishwashing and sterilizing machine.

There are a hot food truck and a cold food truck for every floor. The hot food truck is a four drawer, electrically heated, mobile unit that is easily moved and easily cleaned. A diet maid is responsible for transporting and cleaning her truck. Each drawer of the hot food truck is equipped with two metal racks which divide the drawer into eight sections. This gives a capacity of 32 plates per unit. Before each meal, the dinner plates are placed in the truck to be preheated. The hot food is then placed on the plate, according to the selective menu which the patient has checked. The individual patient menu slip is also placed in the hot food truck with each hot plate. When the food has been served, the diet maid wheels the truck to the ward kitchen where the patient's tray is assembled.

The cold food truck transports desserts and salads. These are also put on plates in the main kitchen. Bread, butter, fruit juices, coffee, cereals, soups, gravies, milk and cream are sent to the ward kitchen in bulk. Gallon size heat-retaining containers are used for coffee. A count is placed in



Wire racks in the food warmer hold eight plates in each of four drawers—32 plates per unit.



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JOHN SEXTON & CO., CHICAGO, 1953

the ward kitchen, indicating the number of beverage, bread and butter orders which are required for each meal.

In the individual ward kitchens, each patient's tray is set up by the diet maid. The tray setup includes tray cover, napkin, salt and pepper and sugar, as well as silver, cup, saucer and bread and butter plate. When the hot food truck is brought to the floor, the nurse assembles the patient's tray. The nurse, using the patient's menu slip as a guide, adds the soup, dessert, bread, butter and beverage to the tray, and places the hot cover over the hot plate. The tray is now ready to be taken to the patient by a hospital aide.

We have found that this method has many advantages over bulk service. The time previously required for meal serving has been cut approximately one-third. There is greater patient satisfaction, greater dietary control, and improved kitchen efficiency.

The food is served from the range directly to the patient's plate which, in turn, is placed immediately into the heated food truck. Food is hot when it reaches the patient. Also, food does not deteriorate as rapidly and is more appetizing.

Because the trucks are easily moved and cleaned, each diet maid can care for her own truck, thus eliminating a truck boy. Plates are preheated in the hot food truck which saves storage space. A dietitian supervises each patient's plate to maintain better diet control. The kitchen worker takes greater pride in his work, its quality and appearance, and, most important, because he prepares their plates, he feels more closely associated with the patients.

This type of food service has proven most successful for the Faulkner Hospital. It has made for greater efficiency, better patient satisfaction, and improved morale of the dietary worker.

How to Allocate Food Storage Space

JANE SEDGWICK PIRKEY
Food Administrator, California Youth Authority, Sacramento

FOOD allowances can be expressed in pounds of food per person per day on an "as purchased" basis. Food groups are used to state the requirements. The allocation of storage space in and for food service departments may be calculated directly from the food allowance. In order to determine the space allotment accurately, considerable preplanning information is needed, such as:

1. The bed capacity of the institution.
2. The peak load of meals for employes or ambulatory patients.
3. The average three-meal-a-day count over a period of a month.
4. The normal stock of perishable supplies (three to four days).
5. The normal stock of staple supplies (one month, two months, or three months).
6. The food allowance (classified into food groups) in pounds per person per day.
7. A table of commissary and kitchen food storage space requirements which lists:
   a. Commodity
   b. Quantity unit

Table 1—Commissary and Kitchen Food Storage Requirements

A.—Location, Time, Temperature

Commodity	Quantity Unit	Period of Supply		Kind of Storage	Temperature Fahrenheit
		Main Commissary	Kitchen		
Meat, carcass	lb.	2 weeks	1 week	Refrigerator	36°-40°
Meat, cut	lb.	None	3 days	Refrigerator	36°-40°
Fish, fresh	lb.	None	1 day	Refrigerator	36°-40°
Eggs, fresh	crate	2 weeks	1 week	Cold room	45°-50°
Milk, fresh	gal.	None	3 days	Refrigerator	45°-50°
Milk, fresh ½ pts.	crates	None	3 days	Refrigerator	45°-50°
Milk, canned	No. 10 can	3 months	1 week	Dry	Cool
Milk, powdered	lb.	3 months	1 week	Dry	Cool
Cheese, American	lb.	1 month	1 week	Refrigerator	36°-38°
Ice cream	gal.	None	1 week	Refrigerator	0°-10°
Butter and margarine	lb.	1 month	1 week	Refrigerator	45°-50°
Bacon 14/16 lbs.	lb.	1 month	1 week	Refrigerator	36°-40°
Salt pork 14/16 lbs.	lb.	1 month	1 week	Refrigerator	36°-40°
Shortening	lb.	1 month	1 week	Cool	45°-50°
Oil	gal.	3 months	1 week	Dry	Cool
Grain products	lb.	1 month	1 week	Dry	Cool
Legumes	lb.	3 months	1 week	Dry	Cool
Sugar	lb.	3 months	1 week	Dry	Cool
Vegetables and fruit, fresh	lb.	None	3 days	Cold room	45°-50°
Potatoes	lb.	2 weeks	1 week	Cold room	45°-50°
Onions	lb.	2 weeks	1 week	Cold room	45°-50°
Vegetables, canned	case	3 months	1 week	Dry	Cool
Fruit, dried	lb.	3 months	1 week	Cold room	45°-50°

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Table 1—Commissary and Kitchen Food Storage Requirements (Cont.)

B.—Method, Container, Space Requirements

Commodity	Type of Storage	Sizes of Containers	Average Container Contents	Sq. Ft. Floor or Shelf Space per Container	No. of Containers in a Stack
Meat, carcass	Track and hooks	1 line ft. track per ¼ carcass	150 lbs. per ¼ carcass	2	1
Meat, cut	Tubs on floor	24" x 10½"	40 lbs. per tub	per ¼ carcass 3.4	1
	Trays on shelves	18" x 26" x 3"	40 lbs. per tray		
Fish, fresh	Trays on shelves	18" x 26" x 3"	40 lbs. per tray	3.4	1
Eggs, fresh	Stacked crates	12" x 13" x 26"	30 doz. per container	2.2 per crate	6
Milk, fresh	Case	13½" x 24¾"	10 gals.		
		Paper bottles 15" $6\frac{13}{16}$" x $12\frac{15}{16}$" x $18\frac{15}{16}$" =	24 — ½ pints		
		$6\frac{13}{16}$" x 14⅛" x $17\frac{15}{16}$" =	35 — ½ pints		10
Milk, canned	Cases on skids	19" x 13" x 7½"	6 No. 10 cans case 37.6 lbs. each	1.7	6
Milk, powdered	Barrel on floor	19" x 28"	200 lbs.	2.5	1
Cheese, American	Bricks or daisies on shelves	13" x 7"	20 lbs.-30 lbs. daisy	1.3	1
Ice cream	Cans—paper containers	9" x 18¼" 9" x 10"	5 gal. can 2½ gal. cans	cabinet	
Butter and margarine	Boxes on shelves	17½" x 14" x 10"	60 lbs. per box	1.7	1
Bacon 14/16 lbs.	Hanging slab or shelf	10" x 2" x 24"	1	1.6	1
Salt pork 14/16 lbs.	Slab	12" x 2" x 30"	1	1.6	1
Shortening	Floor or shelf	16" x 17"	45-50 lb. cans	1.8	1
Oil	Cans on shelves	9½" x 9½" x 13"	5 gals. per can	0.63	1
Grain products	Sacks on skids or 27 gal. G. I. cans	16" x 32" x 10"	98 lbs. per sack	3	6
Legumes	Sacks on floor or 27 gal. G. I. cans	16" x 32" x 10"	100 lbs. per sack	3	6
Sugar		16" x 32" x 10"	100 lbs. per sack	3	6
Vegetables and fruit, fresh	Veg. lugs on floor skids	14" x 17" x 6"	30 lbs. per lug	1.7	5
	Citrus crate	11½" x 11½" x 24⅝"	75 lbs. per crate	1.7	5
	Apple box	10½" x 18" x 11½"	45 lbs. per box	1.7	5
Potatoes	Sack on floor skids	16" x 32" x 10"	100 lb. sack	3	6
Onions	Sack on floor skids	16" x 32" x 10"	10 lb. sack	3	6
Vegetables, canned	Cases on floor skids	19" x 13" x 7½"	6—No. 10 cans in 1 case Wt. 35 lbs.	1.7	6
Fruit, dried	Boxes on floor skids	16½" x 9½" x 6¼" or 12" x 12" x 12"	24 lbs.-30 lbs. per box 75 lbs. per sack	1.56	6

c. Period of supply: (1) main commissary; (2) main kitchen
d. Kind of storage: (1) dry; (2) refrigerator; (3) cool or cold room.
e. Temperature of storage
f. Type of storage: (1) tracks or hooks; (2) floor—skids or pallets; (3) shelves; (4) cans or dollies for bulk goods.
g. Sizes of containers.
h. Average container content.
i. Square feet of floor shelf space per container exclusive of aisles.
j. Number of containers in a stack.

Table 1 lists the commissary and kitchen food storage requirements.

An example of the method of arriving at meat storage space is as follows:

1. The average three-meal-a-day population is determined at 100.

2. The pounds of carcass weight equivalent meat per person per day would be 75 pounds; therefore, one week's supply is 525 pounds; two weeks' supply is 1050 pounds.

3. (Refer to Table 1 for storage space.) Seven feet of track with hooks are needed to hang meat in the main refrigerator for two weeks; *and* a three days' supply in the kitchen storeroom would need 20.4 square feet of floor or shelf space for the storage of cut or oven-ready meat.

Each commodity can be determined and groups of commodities using like storage may be added together.

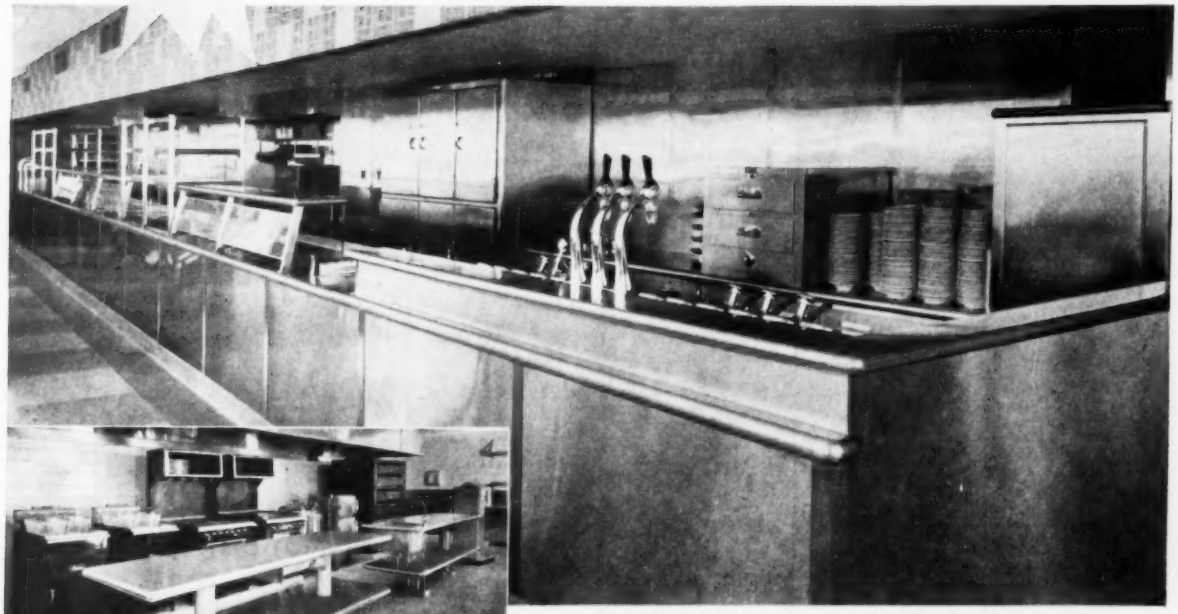
The amount of refrigeration space and dry room storage space necessary should not be a debatable question. The geographic location, the type of menu, and the type of institution served will influence the requirements for refrigeration and storeroom space. The use of a dollars and cents volume or a formula related to the dollars and cents volume of the amount of food purchased are no criteria of the quantity and kind of storage space required. For example, fresh vegetables required considerably more storage space than frozen vegetables and the type of refrigeration is entirely different.

The establishment of a policy, such as the method of serving milk, would influence any decision with regard to the size of the milk refrigerator. Are bulk sanitary milk dispensers to be used or is the milk to be served in half-pint cartons?

The foregoing preliminary planning will furnish the administrator with definite data on the space requirements for storage of foods in connection with his food service department.

ANOTHER FIRST AWARD

Blickman-Built Brass Rail installation wins top honors in Institutions contest



FIRST AWARD—Brass Rail Restaurant, 100 Park Avenue, New York City. Stainless steel lunchroom service counter.

HONOR AWARD—Norton Company, Worcester, Mass. Cooking center showing stainless steel hood, cook's tables mounted on pedestals in kitchen of employee's cafeteria.



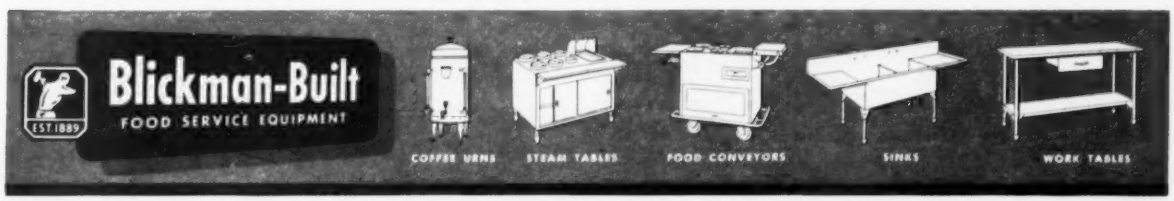
MERIT AWARD—Longchamps Restaurant, Manhattan Apartments, New York City. View in main kitchen showing stainless steel cook's and work tables.

• Three more Blickman-Built installations won honors in Institutions Magazine's 1953 food service contest—a total of 24 awards in 6 years! Only careful planning and fabrication meet the critical standards for good design, sanitation and operating efficiency required of the winning installations. Such features as welded structures, continuous crevice-free work surfaces, round-corner sinks and drawers assure durability and ease of cleaning. For service life measured in years, Blickman-Built stainless steel equipment is your soundest investment. More than 60 years of mass-feeding know-how are behind every project. You can be confident—if it's "Blickman-Built."



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Menus for July 1953

Sister M. Doris
Dietitian
St. Anthony Hospital
Carroll, Iowa

1 Crushed Pineapple Scrambled Egg, Toast • Beef Broth With Rice Roast Beef, Gravy Mashed Potatoes Harvard Beets Fresh Fruit Cup Vanilla Wafer • Fruit Juice Cocktail Escalloped Potatoes With Ham Slices Tomato Wedges on Lettuce Canned Pears Chocolate Cookie	**2** Prune Sauce With Lemon Bacon, Cinnamon Roll • Chicken Broth Stuffed Meat Loaf Creamed Potatoes Parsley Buttered Carrots Cherry Ice Sandwich Cookie • Mixed Vegetable Soup Creamed Chipped Beef on Steamed Rice Peach Cup Salad Spice Cake With Icing	**3** Orange Juice Scrambled Egg • Corn Chowder Salmon Croquettes Whipped Potatoes Broiled Tomatoes French Dressing Apple Pie • Blended Juice Cocktail Cheese Fondue Oven Browned Potatoes Pineapple and Banana Salad With Fruit Dressing Sugar Cookie	**4** Grapefruit Half Pork Links, Toast • Beef Broth With Dumplings Baked Ham Glazed Sweet Potatoes Buttered Fresh Peas Watermelon Wedges • Tomato Juice With Crackers Beef-Noodle Casserole Lettuce Wedge With 1000 Island Dressing Peach Halves Butterhorn Roll	**5** Orange Wedges Broiled Bacon, Bun • Beef Broth With Noodles Roast Chicken, Gravy Bread Dressing Buttered Asparagus Tips Cherry-Nut Ice Cream Wafer • Bouillon, Toast Sticks Cold Sliced Ham Creamed Potatoes Tomato Slices on Lettuce Royal Ann Cherries Angel Food Cake	**6** Applesauce Soft Cooked Egg, Toast • Vegetable Soup Swiss Steak Parsley Buttered Potatoes Baked Carrots Rhubarb Tarts • Orange Juice Creamed Chicken Baked Potatoes Waldorf Salad Whole Peeled Apricots Chocolate Cookie
7 Stewed Fruit Poached Egg, Bran Muffin • Beef Macaroni, ABC Soup Braised Liver With Bacon Slices Mashed Potatoes Broiled Tomatoes Vanilla Ice Cream Macaroon Cookie • Cold Meat Plate Oven Browned Potatoes Buttered Wax Beans Mixed Fruit Salad Gold Cake	**8** Strawberries Scrambled Egg, Toast • Beef Pearl Barley Soup Veal Birds, Gravy Buttered Potatoes Harvard Beets Crusty Peach Cobbler • Consommé, Crackers Beef Roll With Tomato Sauce Orange and Prune Salad Iced Cookie	**9** Grapefruit Sections Sausage, Butterscotch Roll • Chicken Spun Egg Soup Roast Beef, Gravy Browned Potatoes Buttered Carrots, Celery Grape Sherbet Sandwich Cookie • Fresh Vegetable Soup Spanish Rice Grilled Bacon Tossed Greens With French Dressing Pear Halves Cup Cake, Orange Icing	**10** Apricot Nectar Baked Egg, Sweet Roll • Cream of Navy Bean Soup Breaded Fish Fillet Lemon Wedge Whipped Potatoes Buttered Asparagus Cherry Peach Pie • Tomato Bouillon, Crackers Pea and Cheese Salad Escalloped Potatoes Plum Sauce Vienna Finger	**11** Pineapple Juice Soft Cooked Egg, Toast • Mixed Vegetable Soup Broiled Hamburger Steak Mashed Potatoes Broiled Tomatoes Bread Custard With Fruit Sauce • Cream of Celery Soup Meat Soufflé Buttered Green Beans Peach Cup Salad Cinnamon Twist	**12** Grape Juice Broiled Bacon, Pan Roll • Broth With Dumplings Baked Chicken, Gravy Buttered Potatoes Creamed Fresh Peas Celery Hearts Tutti Frutti Ice Cream Vanilla Wafer • Consommé, Crackers Cold Sliced Beef Escalloped Potatoes Lettuce Wedge With 1000 Island Dressing Bing Cherries Daffodil Cake
13 Orange Slices Scrambled Egg, Toast • Beef Broth Smothered Steak Parsley Buttered Potatoes Escalloped Corn Endive Salad Baked Apple With Hard Sauce • Fruit Juice Cocktail Grilled Hamburger on Toasted Bun Harvard Beets Twenty-Four Hour Salad Macaroon Cookie	**14** Grapefruit Juice Poached Egg, Orange Bread • Broth With Noodles Roast Pork, Tomato Sauce Mashed Potatoes Buttered Wax Beans Chocolate Ice Cream Wafer • Grape Juice Chicken Loaf With Mock Hollandaise Sauce Molded Carrot and Pineapple Salad Fudge Square	**15** Prune Sauce Scrambled Egg, Toast • Chicken Rice Soup Beef Stew With Feather Dumplings Buttered Peas and Carrots Leaf Lettuce With Bacon Dressing Vanilla Torte • Bouillon, Crackers Cold Sliced Roast Escalloped Potatoes Fresh Vegetable Plate Whole Peeled Apricots Coconut Bar	**16** Tomato Juice Broiled Bacon, Pan Roll • Broth With Macaroni Rings Chicken Fried Round Steak Mashed Potatoes Parsley Buttered Carrots Orange Sherbet Sandwich Cookie • Blended Vegetable Juice Creamed Chipped Beef Buttered Noodles Peach and Banana Fan Salad Cup Cake	**17** Applesauce Soft Cooked Egg, Roll • Cream of Split Pea Soup Tuna-Rice Casserole Buttered Wax Beans Tomato Slices on Lettuce Rhubarb and Strawberry Pie • Vegetable Chowder Cottage Cheese and Pineapple Ring Salad Baked Potatoes Prune Whip Graham Cracker	**18** Stewed Apricots Poached Egg, Toast • Beef Vegetable Soup Roast Beef, Gravy Riced Potatoes Celery Hearts Buttered Asparagus Tapioca Cream • Consommé, Toast Sticks Italian Spaghetti Lettuce Wedge With French Dressing Royal Ann Cherries Cinnamon Twist
19 Frosted Strawberries Crisp Bacon, Bun • Chicken Noodle Soup Baked Ham With Pineapple Slice Creamed Potatoes Buttered Peas Caramel Ice Cream Sugar Cookie • Tomato Juice Cocktail Crackers Chicken Fricassee Oven Browned Potatoes Apricot and Stuffed Prune Salad Angel Food Cake	**20** Grape-Pineapple Juice Soft Cooked Egg, Toast • Broth, Macaroni Sea Shells Braised Steak Buttered Potatoes Escalloped Spinach With Celery Crusty Peach Cobbler • Chicken Noodle Soup Beef Shortcake Buttered Asparagus Pear and Orange Salad Fig Bar	**21** Grapefruit-Orange Juice Baked Egg, Date Muffin • Beef Vegetable Soup Breaded Veal Cutlets Mashed Potatoes Buttered Beets Chocolate Chip Ice Cream Soda Crackers • Bouillon, Toast Sticks Pressed Ham Potatoes au Gratin Molded Fruit Salad Crumb Cake With Marshmallow Icing	**22** Applesauce With Raisins Poached Egg, Toast • Beef Pearl Barley Soup Roast Pork, Gravy Mashed Potatoes Baked Carrots, Parsley Pickle Relish Gingerbread Turnover • Creamed Chicken on Rusk Baked Sweet Potato Perfection Salad Bing Cherry Sauce Cookie	**23** Crushed Pineapple Broiled Ham Slices • Broth With Dumplings Broiled Steak Buttered Potatoes Creamed Peas Apricot Ice With Marshmallow Sauce Cookie • Consommé American Chop Suey Buttered Asparagus Mixed Fruit Salad Orange Cake	**24** Tangerine Sections Scrambled Eggs, Toast • Tomato Rice Soup Broiled Fish Fillet Parsley Sauce Mashed Potatoes Cabbage and Apple Salad Lemon Cup • Cranberry Juice Cocktail Deviled Egg Salad on Lettuce Potato Puffs Escalloped Green Beans Sliced Peaches Chocolate Chip Cookie
25 Fruit Compote Poached Egg, Toast • Beef Spun Egg Soup Stuffed Meat Loaf, Gravy Buttered Whole Kernel Corn Celery Hearts Orange Ambrosia • Tomato Bouillon Beef Roll With Cream of Green Pea Sauce Grapefruit and Melon Salad Filled Bun	**26** Orange Juice Pork Links, Roll • Beef Rice, Celery Soup Roast Chicken Mashed Potatoes Buttered Peas Fresh Fruit Cup Vanilla Wafer • Vegetable Juice Cocktail Cold Sliced Beef Escalloped Potatoes Peach, Frosted Grapes on Lettuce Lady Baltimore Cake	**27** Fresh Banana Scrambled Eggs, Toast • Beef Vegetable Soup Minute Steak Browned Potatoes Parsley Buttered Carrots Endive Salad Butter Brickle Ice Cream Sugar Cookie • Ham-Noodle Casserole Buttered Asparagus Pineapple Ring and Spiced Prunes on Lettuce Whipped Gelatin Dessert Wafer	**28** Grapefruit, Orange Sections Soft Cooked Egg • Broth With Macaroni Rings Roast Beef, Gravy Mashed Potatoes Buttered Wax Beans Apple Betty • Consommé, Toast Sticks Meat Soufflé Tossed Greens French Dressing Frozen Strawberries Sponge Cake	**29** Rhubarb, Strawberry Sauce Baked Egg, Toast • Fresh Vegetable Soup Braised Liver, Tomato Sauce Mashed Potatoes Minted Apple Rings on Lettuce Cream Puffs • Bouillon, Crackers Cold Sliced Ham Creamed Potatoes Celery Cabbage With French Dressing Pear Halves Sugar Cookie	**30** Orange Wedges Broiled Bacon, Pan Roll • Beef Macaroni, ABC Soup Breaded Veal Steak Parsley Buttered Potatoes Baked Carrots Grape Sherbet Lorna Doone Cookie • Cream of Celery Soup Croutons Luncheon Loaf Lettuce Wedge With 1000 Island Dressing Fruit Cup Gold Cake

31 Fruit Nectar, Poached Egg, Coffee Cake • Corn Chowder, Baked Halibut Steak, Mexican Sauce, Mashed Potatoes, Buttered Green Beans, Raspberry Pie • Golden Rod Toast, Buttered Fresh Asparagus, Canned Grapefruit in Orange Gelatin Salad, Plum Sauce, Marshmallow Cookie.

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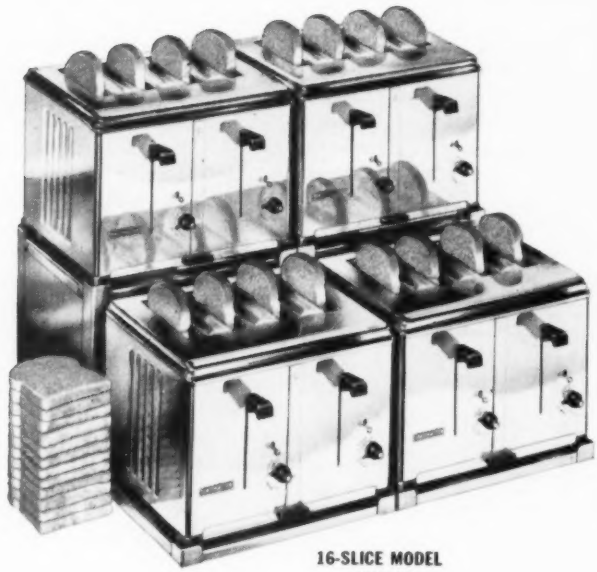


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N.F.P.A. Presents a Guide to Fire Safety

for small hospitals and nursing homes

FOLLOWING the tragic nursing home fire in Largo, Fla., on March 29, in which 32 people lost their lives, urgent requests have come from small hospital and nursing home operators for specifications for fire safety in nursing homes. In response to these requests, the National Fire Protection Association has drawn up a set of recommendations for fire safety in nursing homes to fill the gap until a special N.F.P.A. committee recently assigned to study the problem can develop an official standard.

Robert S. Moulton, N.F.P.A. technical secretary, points out that in the face of the record—147 people killed in 14 fatal nursing home fires in a little more than two years—certain basic precautions for fire safety should be taken immediately by anyone responsible for housing the aged and infirm.

The following recommendations, though temporary from the point of view of N.F.P.A. committee procedure, are in no way meant as temporary measures, later to be replaced, the association explained. Rather, the recommendations will undoubtedly form the basis of the official standard, since the principles involved apply to all fire-safe construction.

THE BUILDING

As in any type of use, a building designed specifically for this type of occupancy is much better and safer than is some former palatial dwelling converted to nursing home use. The fact that the old building has stood for many years is no guarantee that it will not burn tonight.

One-story, fire-resistive construction is best, but any height buildings of fire-resistive construction are considered safe if all stairways and other vertical openings are enclosed and other standard safeguards are provided.

Combustible buildings are inherently unsafe for use above the street floor for bedridden patients, or patients who by reason of mental condition could not be expected to help themselves in case of fire. Brick or stone outside walls do not make a building fire-safe if the interior construction is wood.

The hazard of large buildings can be reduced by fire walls or smoke-stop partitions.

Open stairways, elevator shafts, laundry chutes, and dumb-waiters may act as flues to spread smoke and fire through the building. Smoke alone may be fatal. It is not necessary to build brick walls around stairways to make them safe; in an existing building a light enclosure of wired glass and metal with self-closing wired glass panel doors is quite adequate. Any type of enclosure, with doors kept shut, is better than none. No such problem exists in a one-story building without basement, or having access to the basement only from outside.



Plaster (or plasterboard) walls and ceilings will not burn. Ordinary wallpaper does not add to the hazard unless several successive layers are applied. The amount of wood in doors, windows and frames is not ordinarily enough to create any serious hazard. Combustible fiberboard and ordinary plywood, however, are subject to rapid flame spread, often much faster than ordinary wood is. Experience in recent nursing home fires shows that where such materials are used for interior finish, flame spread is so rapid that there is not enough time to rescue patients. In existing buildings this hazard may be reduced by coating with flameproofing paint. Use only an approved product, applied fully in accordance with directions, and remember that paint only protects the surface—there still may be combustible concealed spaces behind. It is also well to apply flameproofing paint to any large expanse of wood-paneled wall. Wood floors are not important.

Automatic sprinklers, installed to protect the entire building, largely offset most of the structural hazards listed. Most existing buildings of unsafe combustible construction can be occupied with reasonable safety if protected with a standard automatic sprinkler system. A sprinkler installation costs money, but pays big dividends in fire safety. Don't discard the idea of a sprinkler system without investigation; it may be less expensive than you think and there may be incidental savings in insurance. Sprinklers apply water directly on the fire and provide an alarm.



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GETTING PATIENTS OUT

No matter how well constructed and protected the building, there is always a possibility that it may be necessary to get the patients out in case of fire. A single burning mattress, for example, may create enough smoke to force the evacuation of the entire building. Where the entire construction is combustible, the need for speed in evacuation of patients is naturally greater. Survey your situation and decide how you would proceed in case of fire. Even the best of exit facilities may not be adequate without some prearranged plan for their use.

Adequate personnel on duty at all times is the first requisite for effective handling of any emergency. If there is at least one nurse or qualified attendant awake and on duty at all times, fire can be detected in its incipiency, help can be called, and an immediate start can be made on moving patients to a place of safety. A larger number of attendants on duty is obviously necessary where the number of patients is large, or where the property is so arranged that a single attendant cannot have immediate supervision over the entire area.

Exits, arranged at various points remote from each other, provide facilities for safe escape, no matter where a fire starts. The building exits code requires that there shall always be at least two exists as remote from each other as practicable. Exit doors swinging out are not subject to blocking by pressure from the inside. Doors of ample width make it possible to move bedridden patients in their beds, assuming the hospital bed with casters is used and that exits lead out on the level rather than down stairs.

Exit locks and fastenings have been responsible for many deaths in fires. The so-called "panic bar" is the best type of latch; simple pressure from the inside against the bar opens the door. In cases where care of patients requires keeping doors locked, it is doubly important that attendants be on duty to unlock doors immediately in time of emergency. There are systems available whereby locked doors can be released instantly by operating an electrical switch in a central location.

Lighting and adequate marking of exits are important to their effective use. Fires frequently affect electrical wiring systems and leave the building in darkness, greatly handicapping rescue efforts. An emergency lighting system in accordance with the national electrical code is the best answer to this problem. Electric battery lights, flashlights or kerosene lanterns, however, may be used in case of emergency.



Exit drills are highly desirable in nursing homes just as they are in schools and other institutions. With "fire drills" held at intervals, the patients become accustomed to the procedure. In such drills it is not always necessary or desirable to move bedridden patients; alerting personnel and having everything ready may be sufficient.

CONTROL OF FIRE HAZARDS

For safety in nursing homes, it is necessary to give careful attention to all common fire hazards just as in any other type of occupancy.

Heating and cooking equipment of a standard, safe type is a first essential. Avoid any portable heater that can be overturned on contact with combustible material. Any fuel burning heater that is not connected to a standard chimney or flue may be dangerous.

The national electrical code is the proper criterion to follow in electric wiring. An installation in accordance with the code, that is properly maintained, and in which standard fuses of the right rating are always used, will reduce electrical hazards to the minimum.

Smoking is an ever-present hazard. The practical answer here is supervision and the provision of ample, safe ash receptacles.

Good housekeeping and immediate removal of rubbish and other unnecessary combustible material from basements, attics and other out-of-the-way spaces, as well as from living areas, will do much to reduce the amount of fuel on which fire may feed.

ALARMS AND EXTINGUISHERS

It is always prudent to have equipment ready to deal with any fire which may occur despite all prevention precautions.

An automatic fire alarm system to give immediate warning in case fire starts anywhere in the building is highly desirable. Such a system has greatest effectiveness only where it is of a reliable, standard type installed to cover the entire building including basements, attics, closets and other out-of-the-way places where fire might start undetected. N.F.P.A. Standard No. 74 outlines the essential principles of home fire alarm systems. Beware of the unapproved system; an alarm that does not work in case of fire is worse then useless.

Fire extinguishers and hose are highly desirable. Remember, however, that many lives have been lost through ill-advised attempts to fight fire single-handed without calling for help or giving the alarm. Buy only standard extinguishers. The label of Underwriters' Laboratories serves as identification of the quality of the extinguisher and the type of fire for which it is suited. There are many inexpensive small extinguishers on the market which have a good sales appeal but only a limited extinguishing capacity.

Calling the nearest fire department is the first thing to do in case of any fire, no matter if it seems trivial. The fire department would rather respond needlessly many times than take the chance of losing lives because it was called too late. Have a plan for calling the fire department. If there is a city fire alarm box near by, use this. Remember that telephone wires might be burned, and where reliance must be placed on the telephone alarm, have a prearranged plan for using another telephone outside the burning building. If there is no organized fire department near by, have a prearranged plan for calling whatever near-by help may be available.

INSPECTION

The best fire safety plans become ineffective through neglect if there is no regular procedure for checking plans and equipment. This can best be accomplished through a periodic inspection by some outside agency such as a fire department inspector or fire marshal who can review the property from an expert point of view. The outside inspector may note hazards which involve details so familiar to the management of the property that they pass unnoticed.

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One, two, and the job is through! See that little "cartridge" the maintenance man holds in his fingers? This one unit contains all wear-subjected parts of the Crane Dial-ese faucet control, reduces maintenance to two simple operations: (1) Slip out the old cartridge. (2) Replace with a new one.

Crane's Dial-ese faucet controls stand up longer, reduce maintenance costs—and it takes only a minute to replace the Dial-ese cartridge.

Faced with mounting operating costs, hospital administrators are quick to welcome improved equipment to save them money.

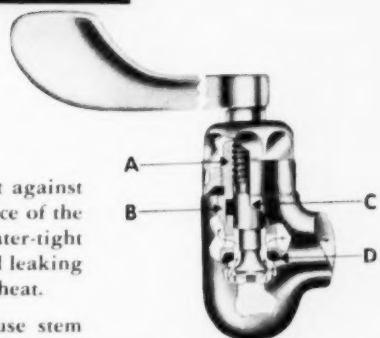
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Dial-ese cuts maintenance time and cost. All moving parts of a Dial-ese control are enclosed in a single cartridge that can be replaced with a new one in less than a minute. It practically eliminates having fixtures "out of service."

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Dial-ese stands up longer because stem threads operate in a sealed, lubricated chamber. Stem packing is below the threads —no liming or corrosion!

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Note these important features of Dial-ese

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B Packing below threads keeps out water, prevents corrosion
C Dial-ese cartridge contains all working parts, lasts longer
D Faucet closes with flow of water

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The V. A Sets Up Housekeeping



TRAINING MANUAL ON MOPPING — 3

FOUR Housekeeping Training Guides, covering sweeping, dusting, waxing and mopping have been developed by the Veterans Administration for use in its hospitals. In this issue, The MODERN HOSPITAL presents the third section of the manual on mopping, which was begun in the April issue. The manual on sweeping was presented in the January, February and March issues.—Ed.

61. Moppy solves the solution problem. There are several important factors in the mopping solution. Each of the following picture-lessons must be discussed and the lesson therein driven home with emphasis.

62. The age-old use of boiling or near boiling water must be discontinued if resilient floorings are to be preserved. The oils and most of the other components of resilient flooring will soon be ruined if extremely hot water is used on them. The mopper must be apprised of the fact that with modern solutions—extremely hot water is no longer necessary or desirable. Make an effort to train your mopper to use warm—but not hot—water.

63. An explanation of the differences between the old-fashioned tallow, high alkali soaps must be given.

It will be well for the instructor to familiarize herself with the hardness of the water in the locality so as to bring in another point of interest and further explain why neither extreme heat nor excessive amounts of soap is necessary where the newer synthetic detergent soaps are used.

64. The soaps we now have do not have as high a content of oils and fats as old types of soap did. They also contain new ingredients which enable the soap to stay in solution—and not scum up the top of the water. Some of these new soaps foam up a good deal, others hardly foam at all. It just does not make any difference whether they foam or not; they still clean much more easily than do the old type of soaps.

A much smaller quantity of these newer soaps is needed. Usually a single ounce (a tablespoonful) will be enough to make a one gallon solution.

65. Moppy practices what we preach. He relies on his soap solution to perform a chemical cleaning. A chemical cleaning is a lot easier on him than the old method wherein he had to scrub hard to get anything clean. When he mixes his solution just right, in warm but not hot water, the dirt literally floats off the surface.

66. Moppy repeats that he wants everyone to be thoroughly aware of the devastating effect hot water will have upon soft floorings.

67. A soft or resilient flooring which has been abused—either with extremely hot water, or with high alkali soap solutions will lose its top surface and become gummy. Once it has become gummy it is ruined forever. There is no cure for a ruined floor. Nor will a gummy floor take a coat of wax.

Every hospital executive should read this story about saving institution interiors.



How the Wrecking Mob was Foiled by a Beauty

Careless, callous or cruel, they'll ruin walls that can't take rough treatment.

Want walls never chipped, scratched or cracked? Learn about Kalistron, the glamour-wall wear can't harm

(—*and its advantages on furniture, too*)

Vinylite is one of the toughest scuff-and-scratch-proof miracle plastics made. *One million grit grinds can only wear one thousandth of an inch into its surface.*

Kalistron is a gorgeous, flexible material for walls. Its top surface (the outside *wear* surface) is PURE, SOLID UNCOLORED VINYLITE! Barring atom blasts or deliberate razor-steel vandalism, *nothing* can visibly scuff or scratch through the PURE VINYLITE TOP of Kalistron.



INSIDE VIEW OF KALISTRON WALL

And . . . the glamorous color of Kalistron is *UNDERNEATH* the Vinylite! Beat, bump, scratch, rub, scuff or roughhouse Kalistron as you wish—you'll never harm the color underneath.

Any wonder Kalistron is called the grandest and toughest wall covering known?

—*and Beauty*

Yet, despite its toughness Kalistron is especially famous for its beauty!

Kalistron is made in 29 colors—to fit into any interior in your building . . . corridors, patient's rooms (great behind beds and other movable furniture), kitchens, pantries, waiting rooms, laboratories. And the colors are not only beautiful themselves but have a double richness because they're seen *through* the Vinylite — a 3-DIMENSION depth. Also — flexible Kalistron can be mounted to any curved wall, or around columns.



Furthermore, Kalistron also is supplied with fabric back to make *perfect* upholstering on furniture that will match the walls.

Best—cleaning ease

Yet, with all these many advantages, hospital men say Kalistron's really top attraction for them is cleaning ease. Dirt just slips off that smooth Vinylite surface. A WIPE WITH A DAMP CLOTH AND — *KALISTRON IS CLEAN!*

Kalistron® finest plastic covering material

Yes, Kalistron is a genuine money-saving wall covering — a great low-cost investment for the building's future—virtually indestructible—superbly beautiful—unsurpassed for cleaning ease. Learn about Kalistron now. Learn about it without any cost or obligation — by ACTUAL TEST.

Send today—at once, while you think of it — for a sample . . . and the *NAIL FILE* TEST KIT.

Yes, we'll send you a nail file with a sample of Kalistron and *dare* you to mar it! See the total wonder of Kalistron. Mail this coupon — learn about the *modern* wall and furniture cover.

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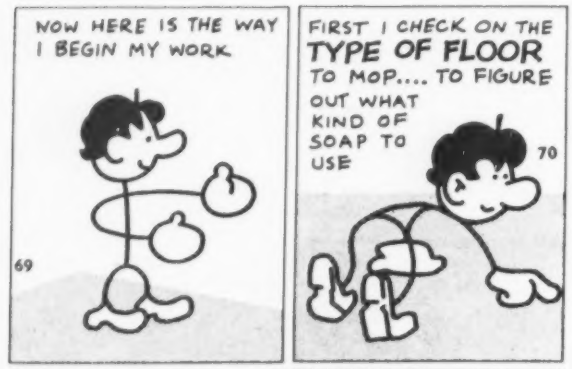
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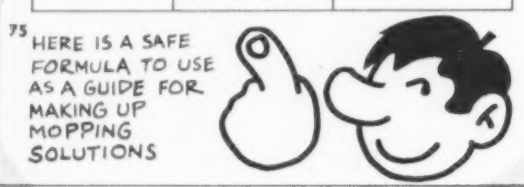








SOIL	HARD SURFACES (high alkali)	SOFT SURFACES (low alkali)
HEAVY SOIL	4 to 6 oz. per gallon	4 to 6 oz. per gallon
MEDIUM SOIL	2 to 4 oz. per gallon	2 to 4 oz. per gallon
LIGHT SOIL	½ to 2 oz. per gallon	½ to 2 oz. per gallon



If wax is applied to a gummy floor it just rolls off and forms in gooey clumps. A gummy floor will not respond to the buffing procedure either.

68. Almost any worker will respond to a recognition of the importance of his comfort, and of his personal appearance. Moppy points out that when a mopper gets sore hands, he has been using too much soap in his mopping solution. Moppy is very interested in how his hands look; he doesn't want them to get dried out or sore.

69. Here Moppy begins to apply his "scientific" methods. He first analyzes his needs. Watch him carefully and learn all you can.

70. His first step is to determine just exactly what type of floor this is. Is it a hard floor—a soft floor—or just what kind is it? This analysis will help him to decide what to do next.

71. Moppy knows that if the floor is not very dirty, he will use only a very mild soap solution. He knows that if the floor is more than a little dirty he must use a slightly stronger soap solution. He also knows that if his floor is as dirty as his finger indicates, he will have to use one of the stronger formulas.

72. Having determined what type of soap formula he needs, he places water in the solution section of his mopping outfit and makes his mopping solution. He puts in neither too little nor too much.

73. The amount of soap powder or liquid soap to be used is determined by the chemical content of each soap or detergent. Therefore, know how potent your soap or detergent is—and use accordingly. Check your soap material for its alkalinity content and for its dispersion qualities.

74. One of the mopper's greatest interests is the lessening of his work load. If he can be convinced that the overuse of soap in his cleaning solution is increasing his work he will soon cut down on the amount he uses. In his effort to reduce his work load, the employe usually argues thus: "If a small amount of soap is good, a greater amount will be better." The worker is forever, whether consciously or subconsciously, trying to force the soap solution to substitute for the brawn he feels he must put forth. When he is instructed to use 2 ounces, he will throw in a handful. The instructor must continuously stress the evils of leaving a residual soap film on floors. If the worker can be made to understand that a residue of soap will attract more and more dirt, and will thereby increase his work load, he will soon realize that he must hold to a prescribed soap formula.

75. Study this formulation chart well. It is the basis for determining the correct solutions.

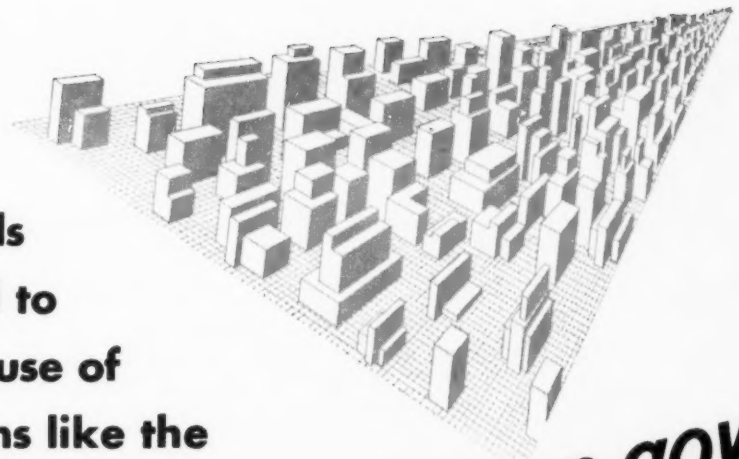
Under "Soil" are listed the determinants, namely: "Heavy Soil," "Medium Soil," "Light Soil." It requires no great mental effort to reason that the heavy soil, which may consist of greases or oils, deeply ingrained dirt, body wastes or medications will require a higher concentration of soap in the mopping solution.

Medium soil is that which is found upon floors that receive only a moderate amount of traffic. Too, the frequency of floor care has much to do with the amount of soil on the floor. The floor which receives daily care will rarely have any deep-seated soil upon it.

Light soil may consist of just a dust film. The area that is far removed from heavy traffic and is only occasionally used will no doubt be a "light soil" area.

The type of surface is also an important determinant in the choice of formula. Please note that this formula chart is divided into two surface types: For the hard surfaces a high alkali soap may be used, whereas a low alkali soap must be used on soft floorings. To go a step further, it is usually advised that the soft flooring should have a neutral (or nonalkali) soap solution. Cleaning materials or cleaning chemicals which veer to the acid side of the pH scale are also harmful and must be used very judiciously.

For a hard flooring with heavy soil, a high alkali soap may be used in the amount of 4 to 6 ounces to the gallon of water. For a hard flooring with medium soil, use a high alkali soap in the amount of 2 to 4 ounces to the gallon of water. For hard floorings with light soil, use a high alkali soap in the amount of ½ to 2 ounces to the gallon. For soft floorings, either a low alkali or a neutral soap should



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be used. Its amount, like that used on the hard flooring, is to be determined by the degree of soil, thus:

for heavy soil—4 to 6 oz. to the gallon of water
for medium soil—2 to 4 oz. to the gallon of water
for light soil—½ to 2 oz. to the gallon of water

76. The language of the average worker can be used by the instructor when an explanation of abrasive powders is being given. Most workers refer to abrasives as "Grit—or perhaps just "scrubbing powder."

The nature of abrasives should be described so that the worker can better understand how damaging they can be to surfaces. If the worker understands that "abrade" means "to cut" it will reduce his desire to use it so profusely. If he can further be shown that each of the tiny edges in abrasives may be little glass-like particles with sharp cutting edges, he will better understand how these will cut the flooring as well as the dirt.

A simple demonstration of this can be performed by placing a few grains of abrasive between two small glass slides. Make a sandwich of the abrasive particles with the glass slides. Then rub the slides back and forth a few times. Note the scratched glass. This same sort of cutting takes place in the flooring and soon destroys it.

77. There are areas (heavily trafficked) where foot soils get ground right into the flooring. None of the normal procedures will remove such soil. Nothing short of an abrasive will cut these soils loose from the flooring. It is often necessary to "abrade" off rubber burns from rubber heels—rubber wheels—rubber casters. These areas should be hand cleaned with as minute an amount of abrasive cleaner as will remove the burn.

78. If the floor surface gets cut through with abrasives—it loses a lot of its immunity to soap solution absorption. If the soap solution seeps through the cuts made by the abrasives the floor will soon be ruined.

79. The importance of rinsing abrasives is very obvious, first, to prevent further cutting, second to remove the unsightly gray-white film which the residual abrasive will leave.

The point of this lesson that must be emphasized is that for every particle of abrasive used, the amount of rinsing must be increased and repeated in proportion to the amount used.

80. Now that Moppy has learned all about sanitation, safety, teamwork, equipment and solutions he is ready to get into action. Let's see what he does first.

81. Moppy has learned that he can do a much better and a much faster mopping job if he clears a space first. He therefore starts his job by first gently lifting or moving as much of the furniture or equipment as he can get out of the area to be mopped.

82. Preservation of property is extremely important. Moppy advises that great care be taken in moving furniture. Floors must be protected from scratches and gouges. Walls and woodwork must be protected from dirty streaks or gouges. Everything must be protected from breakage.

83. Moppy knows from experience that gum wads will not be removed by mopping. He must first remove gum before he starts his procedure. He, therefore, makes good use of his scraper and flips all of the gum wads first. He is careful not to press too hard upon the scraper edge and gouge holes in the soft floorings.

84. The protective barricades are important items of Moppy's equipment. They serve two very important purposes: (1) protection for the public from slipping on wet surfaces; (2) protection for the floor until it is dry enough to be walked upon—and it therefore stays clean longer.

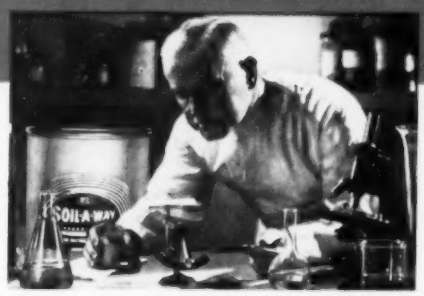
It is important that barricades be provided. They should be easy enough to see so that the preoccupied persons will not fail to notice them.

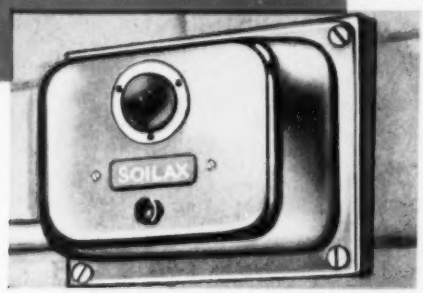
85. If the mopper is taught to keep his back reasonably straight and maintain an easy stance, he will waste much less energy while performing his work. Whatever energy can be conserved through ease of stance and motion, can be used to advantage in terms of better results and greater coverage.

86. If the idea of "rhythm while you work" can be inculcated into the worker's thinking he will find his work much more interesting. Mopping can be done with a great deal of

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rhythmic action. Even the "fanning out" action can be done much better through rhythmic motion.

87. Moppy strongly advises that mopping rhythm be based in the waistline and hipline, and not be confined to the shoulders and arms. Mopping with shoulder and arm action only will quickly fatigue the mopper and the result will be poor work. Demonstrate the free moving, hip action mopping stance and technic.

88. While it is not advisable for the mopper to sing or whistle while he works, it is advisable to try to keep him in a good frame of mind. The relationship of good psychology to good results must not be ignored. Without good psychology—and a good frame of mind—the mopper's "dead-end" type of daily job might be devastating to his morale. Therefore it is much better to associate the rhythm of work to the rhythm of inner music to obtain the best results.

Moppy's theme song is "I'm an old mop-hand—and my work is grand." The lyrics and music of "I'm an Old Cow Hand" are familiar to most every mopper. If he can be imbued with this feeling of rhythm—he will be less likely to dwell upon his personal problems, and his monotonous job, and will perform a much higher standard of work.

89. Here the instructor has an excellent opportunity to dwell upon the merits of a clean mop. Moppy poses this question: "How can you expect to get a floor clean with a dirty mop?" To get any surface clean, one must have clean equipment to start with. The dirty floor which has been mopped with a dirty mop is still a dirty floor.

90. The mop has to be deeply immersed in the mopping solution. It must be worked around in this solution until every strand of it is reached. If by chance a cleaning chemical is used which does not have a sudsing action, the instructor is to point this out. The worker must be made to understand that the suds don't do the cleaning; the cleaning is done by the specific agent which is encompassed in the soap compound.

91. Moppy has a dual purpose in this lesson. First, he does not want to have so much solution on his mop that it will splash all over the place. Second, he likes to have his equipment look nice—he doesn't like to have his buckets or his mop-dolly become covered with hard-to-remove caked soap solutions.

92. Moppy starts in the far innermost corner of the room and gradually works his way backward and out of the room as he finishes. Thus, he does not get into his own way, nor

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does he have to walk over the clean floor as he backs out of the room.

93. A mop full of solution will efficiently cover only about 72 square feet of floor area. Too, this is a comfortable amount of space in which to work.

94. He has a nice work area and a good starting point. He is not so crowded as to get too near baseboards with his mop and therefore will not splash the baseboards.

95. This lesson contains several pertinent points:

1. The "fan" motion.
2. The consistent overlapping motion.
3. The "take half" safety principle.

The Figure 8 fan motion is a "natural." It permits of rhythm; it wets the floor with the least number of motions. The "overlap" value of the Figure 8 motion ensures that every inch of the area being mopped will be covered with the solution.

The "take-half" safety principle should be introduced here and discussed at great length. By taking half—and leaving the other half of the floor dry and open to traffic—Moppy does a great public service. Through this precaution he forestalls many slip accidents and protects the newly cleaned half from messy foot tracks.

96. Can you imagine the consternation of the patient who must take such a "bumping"? If he is very sick this bumping of the mop against his bed would be dangerously disturbing. It would not take many such bumpings to have the bed legs splashed up either.

97. Here the importance of not splashing onto baseboards or up onto walls must again be emphasized. Moppy teaches that the mopper must approach the baseboard area gingerly, with a slow, nonsplashing action. To go a step further, the instructor must demonstrate how Moppy does approach the baseboard cleaning. Though this step is not shown—it is performed as follows:

Moppy stoops down, takes a handful of the mop strands and with them, washes, rinses or dries the baseboard with a manual operation. This rounds out the baseboard and "corners" mopping procedure.

98. The instructor should point out the flying drops of water which are shown here. When the wet mop hits against the baseboard it is very common for droplets of cleaning solution to rebound onto any adjacent surface. These droplets cannot be left upon the spotted surface for they would create an unsightly appearance. Too, if they are not immediately removed they may cause a degeneration of the painted surface—be it wall, woodwork, or baseboard. Added to this, it will create a gummy spot which in turn will act as an adhesive for new dirt accumulations.

99. Baseboards and corners are dirt-catchers. They will need more than mopping care to keep them acceptably clean. A hand scrubbing or a thorough hand washing must be performed with reasonable frequency.

100. Small operations which must be done on hands and knees can be very onerous, especially if the operation has any physical difficulties. It is therefore well for the instructor to acknowledge this—and to show enough concern for the employe to provide a comfortable knee pad. The knee pad shown here is a rather soft latex pad. It may be covered with a clean slip cover, or used as is. If the top can be kept clean the worker will not soil the knees of his uniform while kneeling upon dirty surfaces.

101. There are several reasons why the deck-brush must often be used: A scrubbing machine may not be available; the floor may have deeply imbedded soil which ordinary mopping methods will not remove; the noise of an electric machine may be objectionable. In these cases the use of a deck brush is an expedient answer. It is often good technic to use a combination of mop and deck brush. The deck brush can be used to root dirt out of corners and it can also be used to "spot-scrub" in heavy traffic areas and where stubborn dirts are imbedded.

102. Again, we show consideration for the worker. A "standing up" scrubbing job much easier than a kneeling job.

103. This is the easiest method of floor scrubbing. Scrubbing can be much more efficiently performed with a mechanical scrubber than with any manual methods.

(The fourth section of the training manual on mopping will appear in the July issue of this magazine.)

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THE DISASTER PLAN WORKS

(*Continued From Page 84*)

halls and rooms. After examination and medication, x-ray tests were made if indicated, and some of the victims were evacuated to the hotel, motels and private homes of citizens with the injunction to return in the morning for tetanus antitoxin and further care. Ambulances were on hand to transfer patients who needed special care to hospitals in Marion, Mullins, Bennettsville and Florence, S.C., as well as to Lumberton and Fayetteville, N.C. Before any patient left St. Eugene Hospital his name and address and the place to which he was being evacuated were recorded. This record of the victims helped immensely when the long-distance calls began. Hot coffee for stimulant and good cheer was given to patients and workers by the bevy of volunteers.

Through it all the peace, calm and orderliness did much to expedite the work, for it was a marvel to care for 125 victims within the four hours without a panic. The organized work of the rescue squad and the proximity of the hospital, the professional and personal attention to the individual gave that feeling of security which did the trick. Besides the three fatalities on the scene, after three weeks only two more deaths had been reported. No deaths occurred at St. Eugene Hospital.

Everybody—doctor, nun, nurse, priest, minister, volunteer—gave of himself without stint, regardless of race, creed or color. The Sisters of St. Mary will ever keep this in remembrance. The people of Dillon and Latta, besides giving their time for bedside care and secretarial work, also pitched in to prepare food, arrange meal trays, wash the dishes, shave the male patients, and shampoo the hair of the female patients, and brought in flowers and delicacies as well as cigarets.

The Red Cross volunteers set up an information booth in the hospital, and the telephone company gave them a special wire so they could take care of messages, as well as doing the thousand and one things that Red Cross does the world over. The railway personnel was of great assistance also. Reporters and photographers from newspapers, particularly from the North, gave publicity and rendered information—and even used television to allay the fears of the victims' kin. The patience and cooperation of all were greatly appreciated.

Should anything of the sort occur again, members of the medical profession should be instructed to pick out two secretaries (their wives or office workers, or perhaps other dependable people) who would follow them closely and make notes of the name and address of each patient treated, what ministration was rendered, what diagnosis was made, where the patient was evacuated, and the name of the doctor who cared for the victim. We find that records were not made on ambulatory patients (on the whole) unless they returned the next morning. In many cases treatment apparently was not necessary, but from the legal standpoint, and in the event of any further manifestation of injury, it would prove a safeguard.

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LOYAL DAVIS

(Continued From Page 76)

the committee on ethical relations of the society, however, the truth or falsity of Dr. Davis's statement was not discussed; nor was there any discussion of fee-splitting in two later meetings of the executive council, which considered charges against him. Consideration was confined to whether he was guilty of unethical conduct as a member of the Chicago Medical Society in making a public statement as a regent of the American College of Surgeons. In the verdict, therefore, Truth was not to be the test of moral purpose!

There was no question of whether the fee-splitting problem was an increasing one in Chicago, as Dr. Davis spelled out in his statement before the committee on ethical relations. Actually, to prove this, he needed to go no further than the resolution then pending before the society proposing that the code of ethics be redefined to make fee-splitting ethical. This resolution ultimately resulted in a reaffirmation of the A.M.A.'s principles of medical ethics, coupled with a request that the A.M.A. consider amending its code to define proper conduct, responsibilities and billing procedure when two or more physicians take care of a patient.

The five members of the committee on ethical relations voted 3 to 2 to find Dr. Davis guilty of unethical conduct, two members submitting a strongly worded minority report in protest of the action. On February 10, the council of the society first approved the committee's majority report and then tabled it. On March 10, the council rescinded approval of the majority report by a vote of 42 to 32. Action was then taken to drop the charges. A resolution nonspecific as to individuals was passed deploring use of the public press in fighting unethical practices.

The punishment for conviction of unethical conduct is expulsion, suspension or censure. No one of these penalties was imposed upon Dr. Davis, so the result could be interpreted only as an official vindication of his conduct.

At a subsequent meeting of the college's board of regents, whose right of public protest against a well defined and widespread evil had been challenged, the following statement was adopted and issued to the press:

"From its beginning, the American College of Surgeons has been dedicated to the elevation of the standards of surgery, raising the qualifications for the training of surgeons, and the improvement of hospitals for the care of patients.

"It has demanded from its fellows strict adherence to the canons of medical ethics and has vigorously opposed all movements to lower or violate the ethical principles which should govern the relations between patients and doctors.

"The American College of Surgeons has always contributed to the education of the profession and the public to the end that the care of the patient may be improved. The regents of the college believe that the public is interested in the ethical principles which should be applied between the patient and the surgeon with reference to financial arrangements, the indications for surgical treatment, and the qualifications and identity of the surgeon.

"A small minority of the medical profession chooses to circumvent its moral and ethical responsibilities and strongly resents any action which calls the attention of the public and the profession to its wrongdoing. This group desires to keep the knowledge of these unethical practices from the public and to silence all doctors of good will who decry conduct which is prejudicial to the best care of the sick. Professional men, as well as businessmen, should welcome the opportunity to profit from criticism. It is inconceivable that the medical profession as a whole can be injured by exposing and weeding out those relatively few who violate or evade the high traditions of the medical profession.

"The regents of the American College of Surgeons believe it to be their duty to inform the profession and the public concerning these ethical and professional principles by all the methods of communication now available. They will continue to speak as a body, charged with the formation of policy for the American College of Surgeons, to maintain the high standards of surgical practice which the college has fostered. In these efforts, the college invites and hopes for the cooperation of all other medical organizations."

Thus ended the strange case of Loyal Davis, happily spared the thorny crown of martyrdom. Fee-splitting continues; so does the fight against it.

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NEWS DIGEST

Upper Midwest Hospital Conference . . . Sister M. Bernardine Heads North Dakota Association . . . North Carolina Health Center Dedicated . . . Strike Injunction Appealed in Minnesota Court . . . A.M.A.'s Annual Hospital Report

Upper Midwest Hospital Conference Introduces New Technic in Program Planning

MINNEAPOLIS.—The Upper Midwest Hospital Association meeting here May 13 to 15 made an experiment in the program of its opening session, which resulted in the promptest and highest attendance that Upper Midwest has had at the morning meeting. The program committee worked out a panel discussion on the theme, "What's New in Products, Equipment and Technics," at which Ray Swanson, president of the assembly, presided. Members of the panel were Roy Johnson, American Hospital Supply Corporation; Richard K. Fox, assistant superintendent, St. Luke's Hospital, Duluth; Warren Soderberg, chief engineer, Northwestern Hospital, Minneapolis; Louis B. Blair, superintendent, St. Luke's Methodist Hospital, Cedar Rapids, Iowa; Warren Hempstead, sales manager, Physicians and Hospital Supply Company, Minneapolis, and Margaret Filson, nursing consultant, University of Minnesota, Minneapolis. The meeting was moderated by Everett W. Jones, publisher of the *Hospital Purchasing File*.

Each panel member expounded briefly on some topic of importance in the hospital field. Mr. Johnson discussed textiles and pointed out the advantages of spun-glass fibers in making fireproof draperies for hospitals. Mr. Fox explained the greater flexibility in hospital accounting afforded by the use of machines.

In discussing hazards in electrical systems, Mr. Soderberg pointed out that, owing to the increased use of portable electrical equipment, the wiring systems in many older hospitals are inadequate. "We must consider the possibility of shut-downs caused by overloading of electrical circuits with resulting hazards to patients and the possibility of serious fires," Mr. Soderberg said.

Mr. Blair condemned the policy of overcharging for x-ray and laboratory services to make up losses in the day-rate charges, and pointed out the necessity of accurate cost accounting systems so that charges for the various services would be based on actual costs. Mr. Hempstead took the audience on a "trip through the hospital" and pointed out interesting developments in equipment and supplies. "As an example," said Mr. Hempstead, "look at the time-saving and increased patient-safety factors resulting from the use of plastic disposable tubing for parenteral therapy."



Left: Ray Swanson, Swedish Hospital, Minneapolis; Center: President Louis B. Blair, Cedar Rapids, Iowa; Right: J. M. McIntyre, president, Winnipeg Hospital Association, Manitoba.

Miss Filson discussed present day nurse-patient communication systems. Everyone must be thoroughly instructed on the use of this labor-saving device if hospital people are to get the most out of their investment, she asserted.

Following these short presentations, Mr. Jones led a round table question and answer period, during which many questions were raised from the floor. Answers to these questions revealed the economies inherent in various technics and equipment, including the following: the application of washable, relatively indestructible materials to wainscots in corridors and wards; beds that can be adjusted in height to meet the patient and nursing needs; devices

(*Continued on Page* 178)

Sister M. Bernardine Heads North Dakota Association

DICKINSON, N.D.—Sister M. Bernardine, O.S.F., administrator of St. Elizabeth's Hospital in Drayton, succeeded Arne Bjorke, administrator of the Good Samaritan Hospital in Rugby, as president of the North Dakota Hospital Association at its annual meeting held April 21 and 22 at the Ray Hotel here.

The following officers were elected at the business meeting: president-elect, Byron Jackson, administrator of St. Luke's Hospital, Fargo; vice president, Alma B. Carstens, administrator of the Kenmare Deaconess Hospital, Kenmare; treasurer, S. J. Berhow, administrator, Good Samaritan Hospital, Williston; trustees, Arne G. Bjorke of Rugby; Sister Andriette, O.S.B., administrator of Garrison Memorial Hospital, Garrison; Ernest Hassinger, business manager, Memorial Hospital, Hazen; Rev. Father Anthony Peschel, Casselton, and Sister M. Elenius, Minot.

Balancing the budget is an association problem, it appears. Mr. Berhow, in giving the treasurer's report, said that the association had spent $700 more during the past year than it had received, and this excess of expenditure had come out of reserves. He recommended that a committee be appointed to study association dues and to consider an increase.

The opening session featured a round-table discussion on cost control in every hospital department. Everett W. Jones, vice president of The Modern Hospital Publishing Company, was moderator; the discussants were S. J. Berhow; Florence Sweeney, director of nurses, Trinity Hospital, Minot; Mrs. Gene M. James, R.N., supervisor of the central sterile supply department of St. John's Hospital, Fargo; Sister John Baptist, chief dietitian, Trinity Hospital, Jamestown; Sister Gertrudis, R.R.L., medical record librarian, St. Michael's Hospital, Grand Forks; Tal

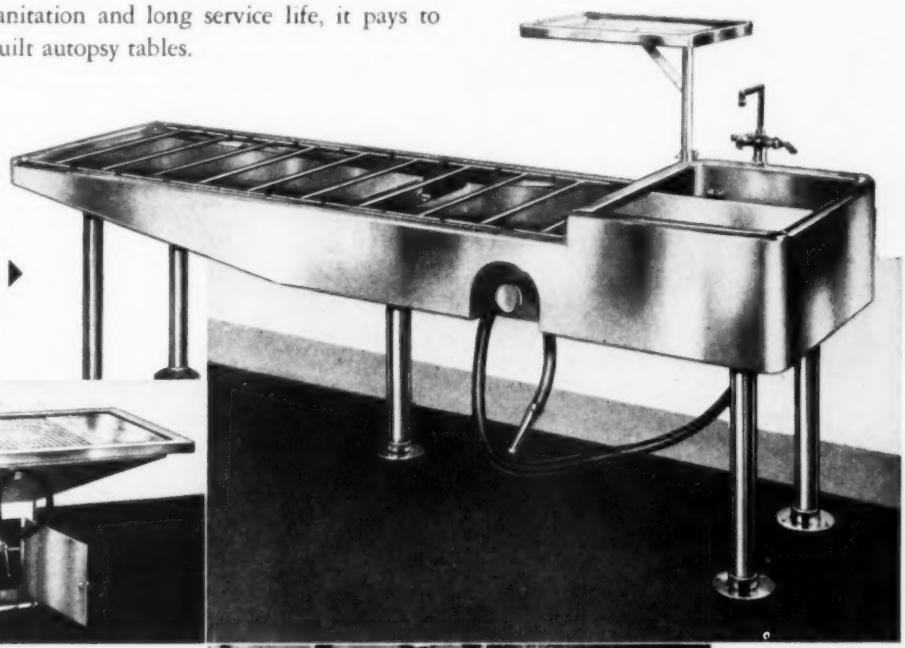
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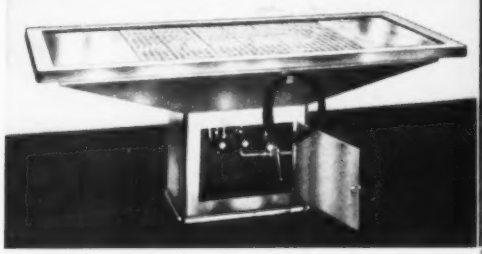
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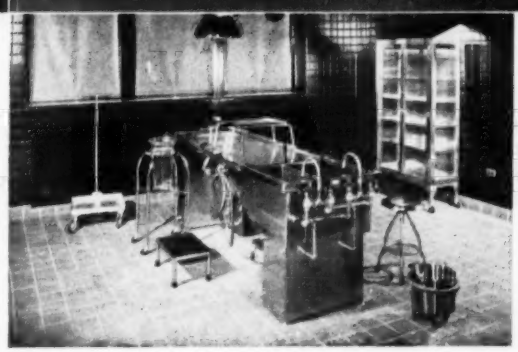


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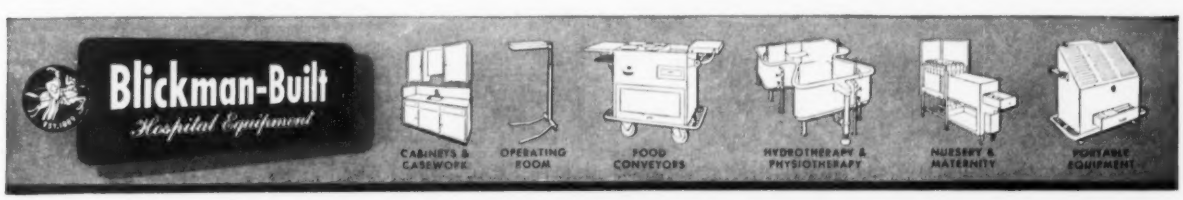


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NEWS...

Statewide Health Plan in North Carolina Lauded at Dedication

CHAPEL HILL, N.C.—Formal dedication of Memorial Hospital, cornerstone of North Carolina's coordinated statewide health program, of the new schools of dentistry and nursing, and of the expanded four-year medical school took place here April 23 and 24.

These new facilities, combined with the university's school of public health and its school of pharmacy, make the University of North Carolina one of the few complete medical centers in the country, Dr. Frank Porter Graham, special mediator for the United Nations and former president of the university, declared in his dedicatory address. Dr. Graham was one of the effective advocates of the Good Health Movement in North Carolina inaugurated a decade ago.

"North Carolina's potential leadership as a health center stems from the creative cooperation of its three great medical schools — at Winston-Salem, Durham and Chapel Hill—and all the colleges, schools and agencies of the people's life," Dr. Graham declared. He cited the provision at the health center for strong central departments, the concentration in one area of the various health services in all the primary fields, the resultant stimulus to research, the expanding program of postgraduate instruction through in-service training and refresher courses, and the development of a team philosophy of service that will be carried into home communities.



At the dedication of the health center (l. to r.): Dr. Frank P. Graham; Robert B. House; Maj. L. P. McLenden, and Dr. Henry T. Clark Jr. enjoy a snack.

"Leaders of the medical profession in North Carolina and leaders of the North Carolina Good Health Association were not stopped by such false cries as socialized medicine and communism," Dr. Graham continued. "Every move to extend the meaning of American freedom and equality of opportunity to the people in small towns and rural comunities has been met by loud alarms and fearful cries of socialism and communism." He thinks the North Carolina "intelligently coordinated local-state-federal program should be extended into local-state-federal nationwide hospital and medical care for all the people."

Dr. John A. Ferrell, executive secretary of the North Carolina Medical Care Commission, reported that 147 projects looking toward a healthier North Carolina have been initiated since the program began in 1947. At that time there were 33 counties in the state without a hospital bed. Today 71 local general hospital projects have been completed, are under construction, or are approved. Seven state-owned hospital projects have been completed, and one, the 100 bed tuberculosis hospital at Chapel Hill, is under construction. A total of 35 health centers has been approved and



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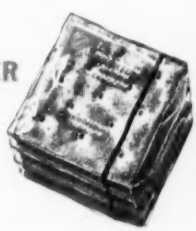
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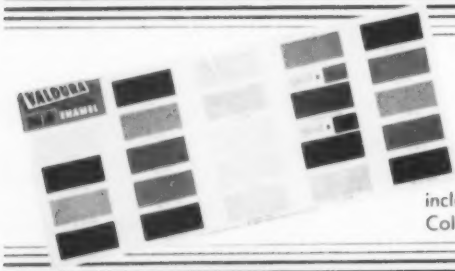
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NEWS...

16 have been completed. Fifteen of 33 proposed nurses' homes have been completed.

Memorial Hospital at Chapel Hill was opened informally last September, with 125 beds available. By the end of next year, it will have 411 beds in the main section and 75 beds in the psychiatric wing.

Heart Attack Is Fatal To Dr. Arthur C. Bachmeyer



Dr. A. C. Bachmeyer

Dr. Arthur C. Bachmeyer, 66, director emeritus of the University of Chicago Clinics and chairman of the editorial board of The Modern Hospital, died of a heart attack May 22 at the Washington national airport. He had been attending a conference of the Commission on Financing of Hospital Care of which he became director of studies last January.

In addition to being director of the university clinics, Dr. Bachmeyer was dean of the division of biological sciences and director of the graduate program in hospital administration. He became emeritus in 1951 but continued to serve as consultant to the university's $10,000,000 building program.

Before assuming his position at the University of Chicago, Dr. Bachmeyer had been superintendent and general medical director of Cincinnati General Hospital from 1914 to 1934 and dean of the College of Medicine of the University of Cincinnati from 1920 to 1934. Dr. Bachmeyer was the only educator to hold the presidency of the American Association of Medical Colleges (1951), the American College of Hospital Administrators (1940), and the American Hospital Association (1926).

The 1950 recipient of the American Hospital Association award of merit, Dr. Bachmeyer served as director of the Commission on Hospital Care which made a two-year study of the hospital needs of the nation that led to the enactment of the Hill-Burton Act.

Dr. Bachmeyer, in addition to his university and national appointments, was a director of the board of the Chicago Blue Cross Plan, treasurer of the American Hospital Association since 1946, and a charter fellow of the American College of Hospital Administrators.

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NEWS...

Both Patient and Birth Records Shattered in 1952

CHICAGO.—An all-time admissions record for patients in American hospitals was made in 1952, according to the 32d annual report of the A.M.A.'s Council on Medical Education and Hospitals carried in the May 9 issue of the *Journal of the American Medical Association.*

The 6665 registered hospitals in the country reported a bed capacity of 1,541,615 and a total of 18,914,847 admissions, or one new patient every 1.6 seconds, the all-time record.

For the first time in the history of American hospitals, more than three million infants were born in hospitals within a year's time. During 1952, a total of 3,170,495 hospital births were recorded, or one live infant every 9.9 seconds. This total represents 80 per cent of the estimated 3,910,000 births in the United States last year.

Highlighted in the 1952 report were the increasing problems of mental health. The 585 psychiatric hospitals have a bed capacity of 732,929, with the highest average daily census ever recorded in this field. It represents 53.7 per cent of the daily patient load in all registered hospitals.

Governmental hospitals last year gave daily care to 688,119 mental patients as contrasted with daily care given 15,937 mental patients in nongovernmental hospitals.

Even though only 1.6 per cent of the total number of patients admitted to all hospitals during 1952 were mental patients, mental hospitals maintained an average daily census greater than the total patient load in all other registered hospitals, indicative of the long period of hospitalization required for such patients.

The average bed occupancy in the hospitals registered by the A.M.A. rose from 84.5 per cent in 1951 to 84.9 per cent in 1952. Governmental hospitals reported an 89.4 per cent occupancy, while nongovernmental institutions reported a 73.6 per cent occupancy. The maximum limit of operating efficiency in general hospitals is considered between 80 and 85 per cent, the report pointed out.

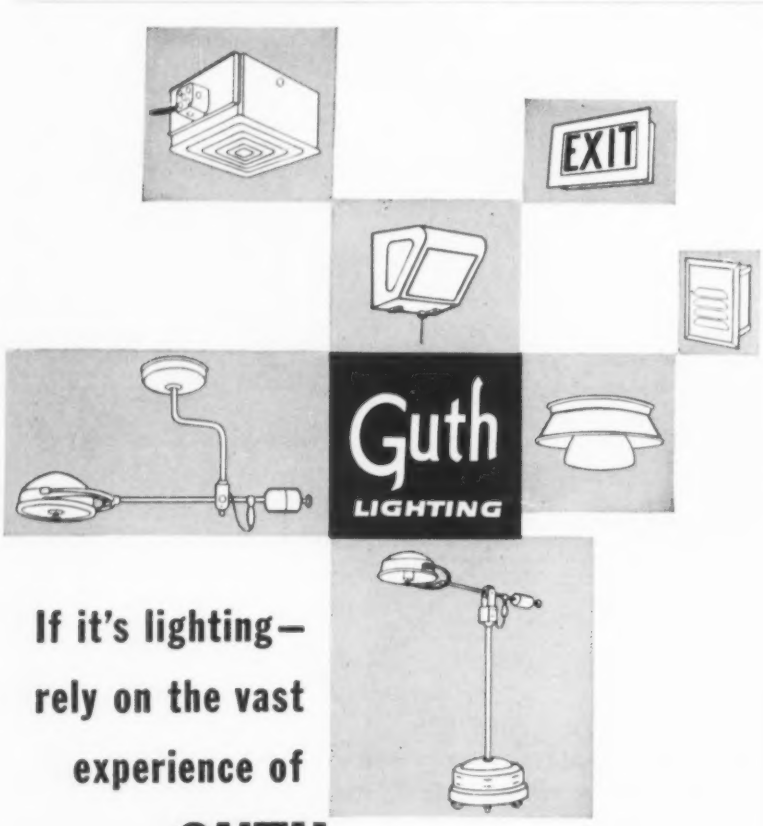
Classification of hospitals by types of service indicated a wide variation in the percentage of beds occupied. In isolation hospitals, 40.9 per cent of the beds were occupied; in psychiatric hospitals, 96.0 per cent; in tuberculosis hospitals, 84.0 per cent; in general hospitals, 74.1 per cent.

The average length of stay in governmental general hospitals was 16.4 days; in nongovernmental hospitals, 7.5 days.

Need for More Nurses, Technicians Told by A.M.A.

CHICAGO.—An acute shortage of well trained nursing and technical personnel still exists despite the annual increase in these fields, according to the 32d annual report of the Council on Medical Education and Hospitals of the American Medical Association. To meet existing shortages as well as anticipated future demands, additional facilities, training programs and personnel will be required, it was added.

Pointing to nursing as a field in need, the report indicated that 225,613 graduate nurses were employed by A.M.A. registered hospitals in 1952, compared to 216,047 in 1951. There



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NEWS...

were only 100,595 student nurses in 1952, whereas the 1951 figure was 103,527. The 1952 graduate nurse figure excluded 31,013 nurses on private duty. A total of 142,045 professional nurses, or 62.9 per cent, were utilized for general bedside care, with the remainder serving in administrative, supervisory or educational capacities.

In 1952 there were 1079 accredited schools of professional nursing, 27 fewer than the number reported in 1951; nearly all schools were sponsored by general hospitals. These schools admitted 42,103 new students during the year—an increase over 1951, but still not sufficient to meet demands, the report stated.

Strike Injunction Leads to Appeal to State Supreme Court

MINNEAPOLIS.—The supreme court of Minnesota has been asked to rule on the constitutionality of the 1949 state law forbidding strikes in nonprofit hospitals.

Local 113 of the Building Service Employes Union, A.F.L., made the appeal following a ruling on April 29 by Judge Rolf Fosseen of the Hennepin County district court restraining the local "from encouraging, participating in, or causing a strike or work stoppage" in nine Minneapolis nonprofit hospitals.

This is the second court injunction the nine hospitals have won against the union, which represents some 700 employes in their institutions. The current dispute between the hospitals and the building service employes has been going on since last December.

It took 18 months to settle the controversy between the hospitals and the union two years ago. The union called a strike at that time but the hospitals' attorneys won a court injunction against the walkout. However, before the case was heard by the supreme court, the strike was settled and the legal suit expired.

This year, following prolonged negotiations, the union again declared it intended to call a strike but it offered to arbitrate on all issues, including seniority and union security as well as vacations and overtime.

The hospitals' reply was that it would arbitrate on all so-called "cost

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NEWS...

issues" but it refused to budge on the union shop, a sore point in the earlier controversy also. The hospitals' attorney also pointed out that the union in filing its contract demands, including the union shop, asked representations not only for employes previously covered but also for practical nurses and other employes already covered by contracts with independent unions.

The language of Judge Fosseen of the district court in ruling the law constitutional is interesting. He denied that the prohibition of the right to strike by hospital employes deprives these employes of "the essential attributes" of liberty. "It is not merely a matter of suspending operations," he declared, "such as might be true in a mill or a factory.

"It is a question of health, safety and, in many cases, the very lives of those persons who need the service a hospital is organized to render." If the act does impinge upon the "unfettered exercise of some of the constitutional guarantees of defendants" it does so "only out of deference to the paramount significance of other public rights."

COURT UPHOLDS PROVISIONS

The court declared that the legislature "had absolute authority to prohibit a strike or a lockout without providing for arbitration." But he defended the arbitration provisions of the law limiting arbitration to "maximum hours of work and minimum hourly wage rates" as covering such issues as vacation, overtime pay, rest periods, sick leave and "other cost items of doing business."

Judge Fosseen further declared that the issue of union security is not covered by arbitration "because the creation of a union shop by compulsion is repugnant to the letter and the spirit of the Minnesota labor relations act."

The district court declined to rule on a charge by the hospitals that the union no longer represents employes and is seeking to enforce an illegal union shop. However, the judge declared that if the law later is ruled unconstitutional, appropriate consideration should be given to the question by both sides and by the state labor conciliator.

The hospitals involved are: Abbott, Asbury Methodist, Eitel, Fairview, Lutheran Deaconess, Northwestern, St. Barnabas, St. Mary's, and Swedish.

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NEWS...

Utah's Blue Cross Plan Cuts Operating Expenses

SALT LAKE CITY.—Addressing the annual luncheon meeting of Intermountain Hospital Service, held at the Hotel Utah here recently, Richard M. Jones, director, Blue Cross Commission of the American Hospital Association, stated: "The public has every right to expect the medical profession, the hospitals and Blue Cross-Blue Shield to work harmoniously together in solving the economic problems resulting from illness."

Mr. Jones pointed out the Blue Cross protection must eventually be made available to the increasing number of older people in our population whose need for hospital care exceeds that of the general average. He also stated that Blue Cross must extend its protection to include the extraordinary expenses arising from dread diseases and chronic illness.



Officers and guests at Intermountain Hospital Service luncheon (l. to r.): Harold J. Steele, Lewis G. Hersey, Richard M. Jones, Sister Mary Margaret, Rev. J. Richard Palmer, and John H. Zenger.

As the main points of difference between Blue Cross and commercial insurance companies, Mr. Jones listed:

1. "There is rarely any representation of hospitals on the governing boards of commercial insurance companies.

2. "There is no legal obligation requiring commercial insurance companies to make payment direct to the hospital, their obligation being to the policyholder.

3. "Commercial insurance companies devote less of their income to payment of benefits than do Blue Cross plans.

4. "Commercial insurance companies will not accept all classes of risks."

Following the luncheon, the annual meeting of Intermountain Hospital Service, Utah's Blue Cross plan, was held under the direction of Sister Mary

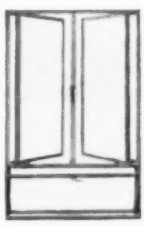
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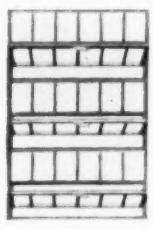
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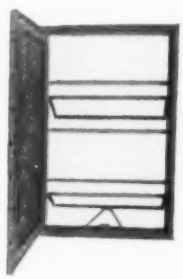
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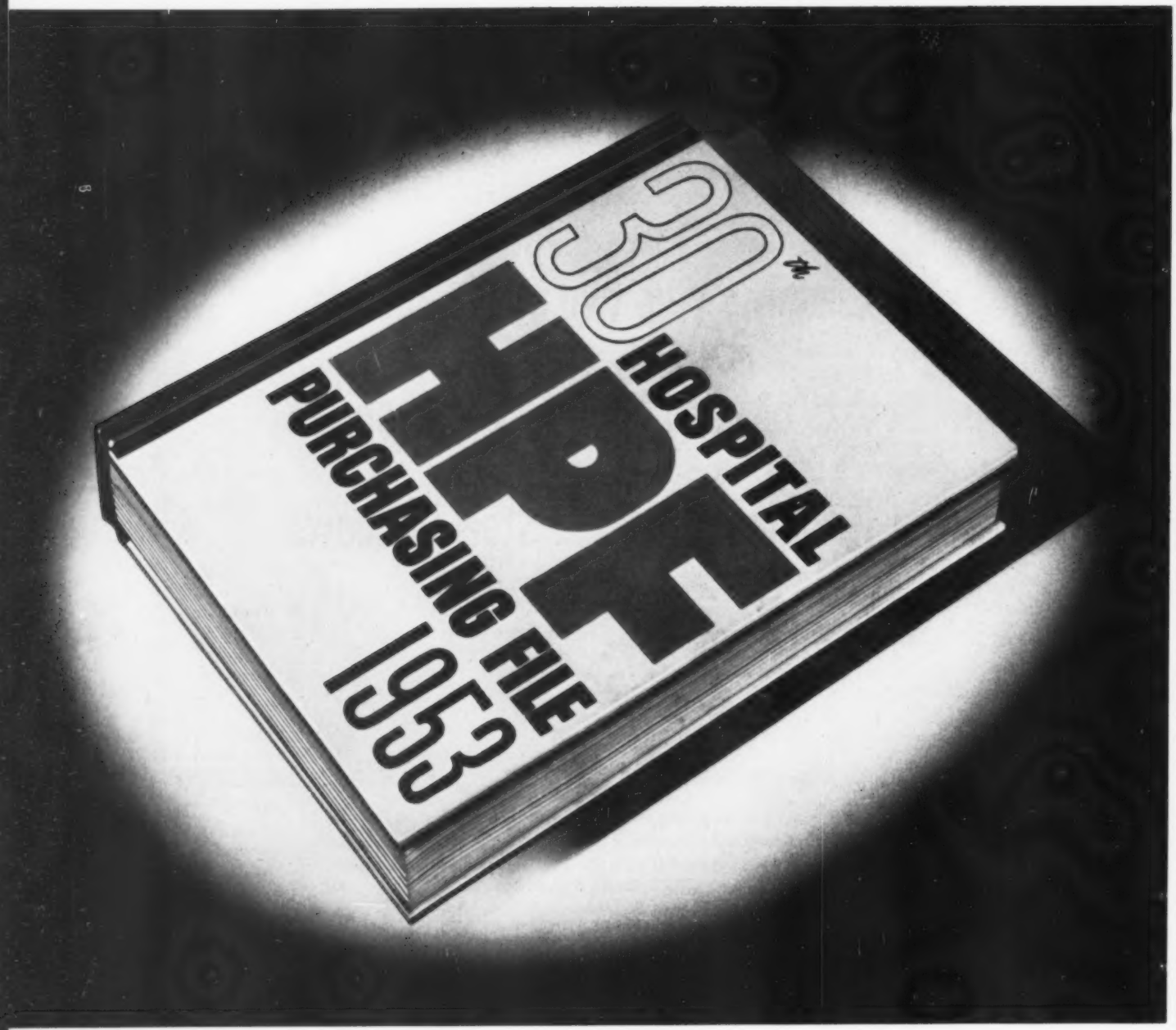
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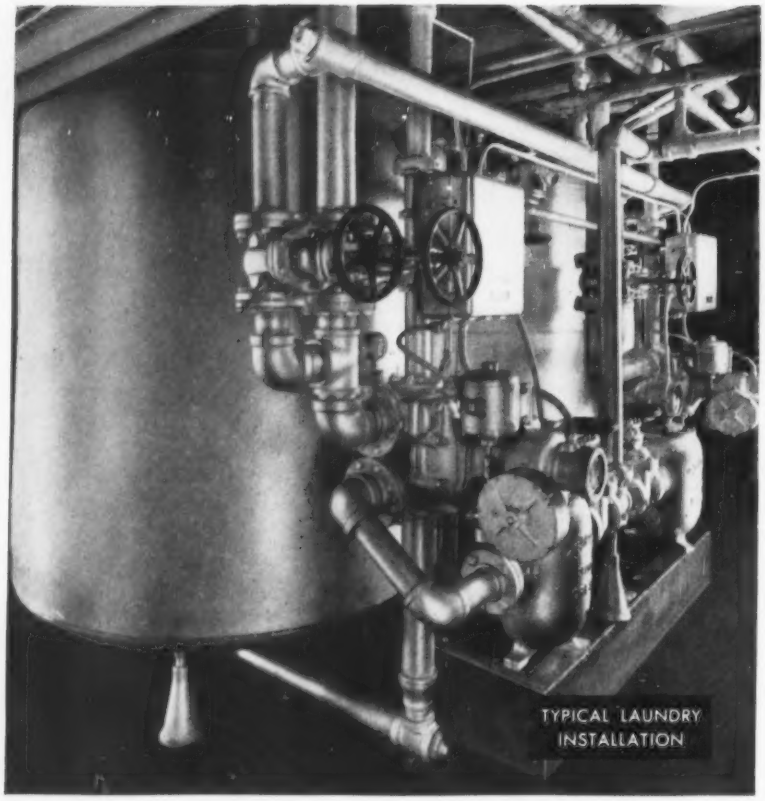
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NEWS...

Margaret, O.S.B., president of the corporation.

It was pointed out that during 1952 the Plan paid 10,123 hospital claims, amounting to $864,059.61. This represented 83.8 per cent of total income. Certain economies effected by the Plan reduced operating expenses to 9.6 per cent of income, enabling the addition of $81,264 to its reserve fund as compared with a $17,407 loss for the previous year.

At the end of 1952 more than 84,534 persons in Utah were subscribing to the Blue Cross plan, and 67,460 were enrolled in the companion Blue Shield plan.

Sister Mary Margaret, O.S.B., administrator of the St. Benedict's Hospital in Ogden, was reelected president for the coming year. Other officers chosen at the meeting were: vice president, John H. Zenger, administrator of Utah Valley Hospital, Provo; secretary, Elmo W. Lund, administrator of Latter-Day Saints Hospital, Logan, and treasurer, Harold J. Steele, First Security Corporation, Salt Lake City.

Health Appropriations Restored for Three Programs

WASHINGTON, D.C.—Following a demand by deans of medical schools relayed by telegrams, some of the budget cuts in "categorical health programs" (cancer, mental health and heart disease) have been restored by the House appropriations subcommittee in closed sessions.

Some of these programs will get as much money for the fiscal year 1954 as they received this fiscal year, or more, under the recommendations of the subcommittee.

The recommendations will fall short of those of the previous administration, it was indicated. The original cuts were as follows: cancer from $22,000,000 to $15,780,000; mental health from $15,500,000 to $9,817,000; heart disease, from $16,500,000 to $11,040,000.

Heads World Health Group

GENEVA, SWITZERLAND.—Dr. Murched Khater, Minister of Health of Syria, was elected president of the sixth World Health Assembly, which met here last month. Dr. Khater succeeded Dr. Juan Salcede Jr., Philippine Secretary of Health.

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NEWS...

Argue Ambulatory Drug Therapy vs. Hospital Care for Tuberculous

LOS ANGELES.—Ambulatory chemotherapy *vs.* modern hospital treatment was the subject of the closing session of the 49th annual meeting of the National Tuberculosis Association held here May 18 to 22. Approximately 2000 persons attended convention sessions at the Statler and Biltmore hotels. Next year's anniversary convention will be held in Atlantic City.

Dr. Cabot Brown of San Francisco warned the delegates that the widespread use of drugs to treat patients on an ambulatory basis might result in the development of "vast reservoirs of drug resistant organisms in partially 'cured' individuals."

"Administration of one of the new 'wonder drugs' may abolish fever, diminish cough, and cause patients to gain weight to a spectacular degree," Dr. Brown declared, "but such favorable response must not be optimistically interpreted as complete victory. *Proper* use of the drugs requires, at least at the outset, hospitalization in order that beneficial and possible deleterious effects can be intelligently observed and evaluated by x-ray and laboratory findings. The proper timing of collapse procedures and surgical removal of diseased lung tissue likewise requires that patients be under close medical observation, which is possible only in the hospital.

"The unfortunate victims of infection by ambulatory patients will be deprived of the benefits of drug treatment," Dr. Brown asserted, in defense of hospitalization of tuberculous patients. "The injustice of this is not diminished when one considers that proper treatment of the original patients from the onset would have prevented them from spreading their disease after diagnosis and that such contacts as had been infected earlier would have been infected with tubercle bacilli that were drug sensitive."

Dr. Daniel Widelock, assistant director of the bureau of laboratories of the New York City Health Department, reported experience in the ambulatory treatment with isoniazid of a group of clinic patients. A significant feature of the study was the change in the behavior of the patients. "A more striking testimonial to the change in the chronic patient when the pessimism of good advice is replaced by the optimism of treatment would be hard to find," he declared.

Although until recently there has been little public recognition of the problem of the unhospitalized patient, Dr. Widelock commented that a more logical approach is now being adopted. "In fact, we face a danger that the emphasis may shift too strongly in the opposite direction and that home treatment by itself may become a method of caring for tuberculosis.

"What is needed at this time," he said, "is not hospital or home treatment, but a plan for the coordinated management of each patient, utilizing to the maximum all the facilities at our disposal. Such a program will call for the application of the most effective chemotherapeutic regimens, given in the home when feasible, in the hospital when not. It will demand the close correlation of medical care in the home with surgical care in the hospital. And it will also require compromise in the allocation of institu-

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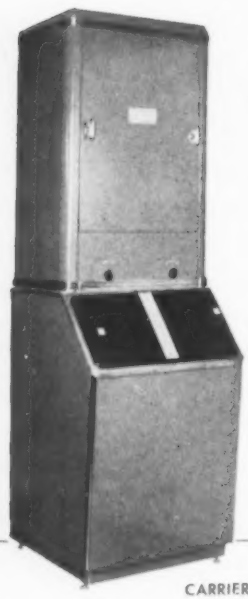
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NEWS...

tional beds between the concern of the clinician with the complete cure of the individual patient and of the health office with the complete protection of the community."

Reporting on outpatient treatment in Cuyahoga County, Ohio, Dr. J. B. Stocklen, tuberculosis controller, said he would not recommend outpatient treatment "if sufficient tuberculosis hospital beds are available."

Of 121 patients with active tuberculosis treated with streptomycin and PAS on an outpatient basis, Dr. Stocklen said that hospitalization was required in 78. The remaining 43, who have been observed for from six to nine months, appear to be recovering, he said.

The major public health problem of the unhospitalized patient, according to Dr. Herbert R. Edwards, executive director, New York Tuberculosis and Health Association, New York City, is control of spread of infection.

Although there are approximately 400,000 persons in this country with active tuberculosis—250,000 of these known to health authorities and 150,000 unreported—Dr. Edwards pointed out that there are only 102,000 hospitals beds for the tuberculous and some of these are not considered acceptable for use.

NEED 50,000 MORE BEDS

Dr. Edwards estimated that 50,000 additional beds are needed for tuberculosis patients but said that it is "highly problematical" they will become available. Therefore, he suggested, ways must be found to make greater use of the beds now available. The intelligent use of drugs prior to hospitalization and following discharge may help solve the problem, he stated.

Dr. Nicholas D. D'Esopo, chief of tuberculosis service at Veterans Administration Hospital, West Haven, Conn., in discussing the papers, emphasized that the use of drugs with ambulatory patients should never be considered except in terms of prolonged chemotherapy and then only with selected patients. He expressed the opinion that drug treatment should not be started on an outpatient basis, even though in some places, such as New York City, this type of experiment might be justified.

Mark H. Harrington of Denver on May 22 assumed office as the first lay president of the National Tuberculosis

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***...Especially* A PRODUCT FOR PATIENT PROTECTION**

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NEWS...

Association since 1945 and the third in the history of the organization. Mr. Harrington is a lawyer.

Donald S. King took office as president of the American Trudeau Society, medical section of the N.T.A. He is a consultant both to the surgeon general of the Public Health Service and to the Veterans Administration.

R. Winfield Smith is the new head of the National Conference of Tuberculosis Workers; he is executive secretary of the Pennsylvania Tuberculosis and Health Association.

Hunter College Opens New Nursing Program

NEW YORK CITY.—A program to prepare graduates of hospital schools of nursing to be team leaders, assistant head nurses, and beginning practitioners of public health nursing in health agencies was announced last month by Prof. Claire Favreau, director of the division of nursing education at Hunter College. The program will lead to a bachelor of science in education degree, with a major in nursing.

The school of general studies at Hunter will offer the program in the evening and day sessions of the college. Graduate nurses admitted to the division of nursing education of the education department will major in nursing.

Scheduled to start in September, the program will consist of the equivalent of two full years of general education and from 22 to 24 credits in nursing.

Younger Doctors Will Fill 1953 Draft Quota

WASHINGTON, D.C.—Induction processing of Priority 3 physicians born prior to Aug. 31, 1922, has ceased, following orders to state directors of Selective Service from the Selective Service System on April 20. This action became possible when the Department of Defense reduced the supplemental call for the fourth quarter of fiscal year 1953 from 500 physicians to 200.

Approximately 3000 physicians in Priority 1 and 2 groups and in the younger age groups of Priority 3 will be completing internships and residencies by the end of June. These special registrants should furnish the pool from which all anticipated requirements can be met.

LABORATORY REPORTS
offer explicit data on the positive protection afforded by dermassage



Where the patient's comfort in bed (1) contributes in some measure to recovery, or (2) conserves nursing time by reducing minor complaints, you cannot afford a body rub of less than maximum effectiveness. You can depend upon Dermassage for effective skin protection *because it contains the ingredients to do the job.*



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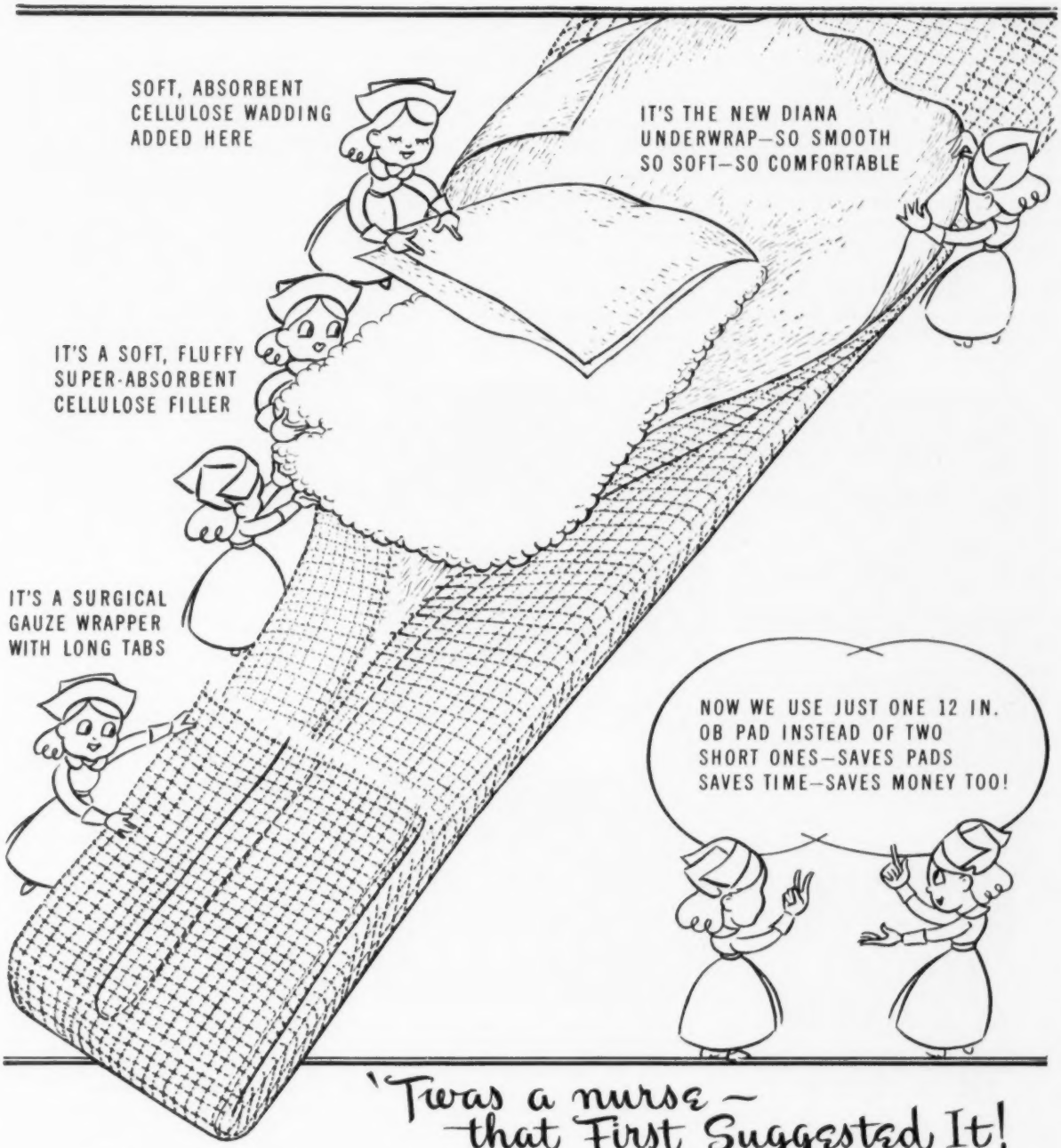
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By the maker — 42 years in this business. By the hospital supply houses. By their trained and expert salesmen.

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NEWS...

Seeks $1 a Year From Negroes for Buildings

BIRMINGHAM, ALA.—The Rev. Dr. Amos H. Carnegie, president of the National Hospital Foundation, speaking here in April, outlined the foundation's plan for the erection of a hospital financed completely by the Negro population of the United States.

Decrying integration as the solution to the Negro's problems, Dr. Carnegie explained the program of the foundation as "a self-help movement, sponsored by our people, to be directed by our people, to be financed by our people, for the purpose of assisting to provide our share of the hospital beds needed to meet our health requirements in communities where we compose a large segment of the population, as we do in Birmingham, where 230,000 of us compose 43 per cent."

The primary interest of the foundation at the present time is the solution of hospitalization problems, Dr. Carnegie said, "We have a simple and painless plan by means of which we can in a short while have a modern 200 bed hospital in Birmingham, without even knowing that we have established it, for we are asking the 230,000 of us in Birmingham for this $1 a year. But we are not only asking the 230,000 in Birmingham for this $1; we are also asking the 17,000,000 throughout the country for a dollar a year. What Birmingham alone cannot do, all of us working together throughout the country can do almost overnight.

"There are 120 cities throughout the country that need a modern hospital, no one of which can provide it for itself, but if all of us work together and build one at a time, we can build one in every city with 10,000 or more of us in 20 years. Birmingham is scheduled to get the first one."

Western Hemisphere Doctors Review Progress

RICHMOND, VA.—Addressing delegates of national medical societies from a score of American nations, as well as guests and participants from 48 states, Dr. Edward L. Bortz of Philadelphia, past president of the American Medical Association, told the first Western Hemisphere Conference of the World Medical Association that fundamental investigations under way in problems of vascular degeneration, cancer, collagen diseases, and mental disorders are a strong hope that the average span of human life can be prolonged during the next quarter century.

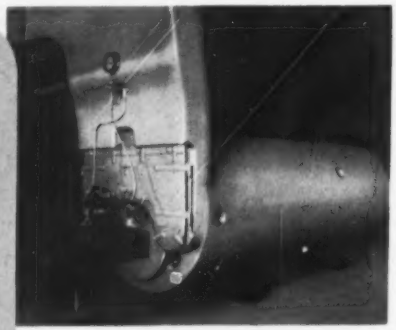
Said Dr. Bortz: "Too many important leaders today are living in the danger zones of poor diet, prolonged fatigue, and unhealthy mental hygiene. Why should not the advances of science be utilized to bring about a greater enjoyment and a deeper appreciation of human values?

"It may be possible in the near future, according to Jean Rostand, for biology to produce a remedy against worry and anxiety as it now can against seasickness."

Guests of honor at the conference were 49 physicians, all born in 1878, from each of the 48 states and the District of Columbia.

The conference was devoted to a review of medical progress and significant fields of medical exploration, and was held here April 21-25.

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Centenary College's new Science Building. Associate Architects: Stone & Pitts, Beaumont, Texas, and Payton & Bosworth, Shreveport, Louisiana.

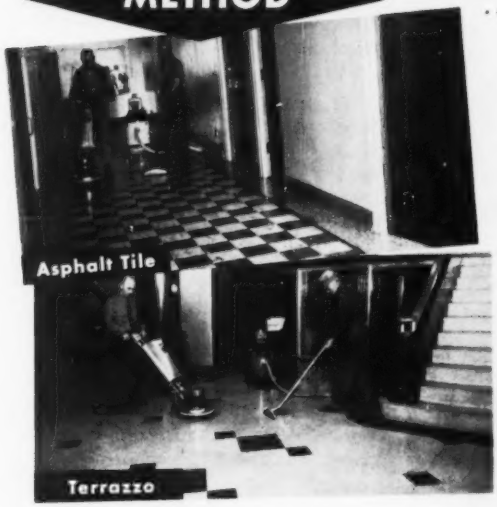
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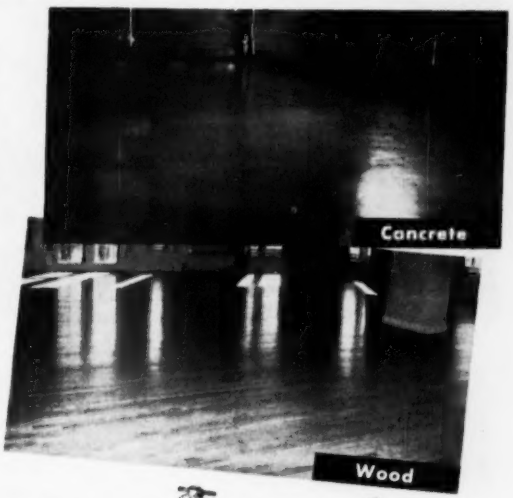


For ASPHALT TILE FLOORS . . . From now on you won't have to wax those asphalt tile floors to keep them good-looking and well protected. Multi-Clean Asphalt Tile Preserver is a complete finish in itself . . . it provides a long-lasting, glossy finish, and is U/L approved as anti-slip. It ensures continuing beauty and protection for all your asphalt tile. If you prefer to continue waxing your floors, you'll find Asphalt Tile Preserver an excellent base for wax. It makes the wax look nicer and saves you money because less wax is needed. With the *Multi-Clean Method*, ordinary dry sweeping or vacuuming and weekly damp mopping keep asphalt tile clean . . . buffing with a Multi-Clean Floor Machine equipped with a polishing brush or steel wool disc will restore the original lustre.

For TERRAZZO FLOORS . . . Now your terrazzo floors can have a brilliant lustre yet be extra-safe to walk upon when they are protected by Multi-Clean Terrazzo Sealer . . . the terrazzo treatment approved anti-slip by U/L. It penetrates and seals the surface against moisture, dirt and grease. Water-clear in color, it will not yellow with age. It gives your terrazzo a beautiful satiny finish. Floors are ready for traffic within 30 minutes after application. This *Multi-Clean Method* requires only dry sweeping and periodic wet mopping for maintenance.

For CONCRETE FLOORS . . . Two types of concrete floor treatments, each formulated to meet your own special floor condition are available to you with the *Multi-Clean Method* of floor care. Both Multi-Clean Neo-Dry Concrete Sealer (rubber-base) and Multi-Clean Concrete Preserver (bakelite-base) provide tough finishes that resist scuffing and wearing, that are not affected by water, grease, oils, or alkalies, and will not peel, chip, or fade with age. They'll give you an excellent base for wax, cut sweeping time and reduce the need for damp mopping.

For WOOD FLOORS . . . The speed and ease with which your wood floors are kept in first-class condition with the *Multi-Clean Method* will reduce your maintenance costs. Even under heaviest foot traffic, your floors will retain their safe, glossy finish for longer periods between treatments. Ordinary dry sweeping will keep them clean, and periodic polishing with a Multi-Clean Floor Machine will remove the usual surface dirt and scuff marks, restoring brightness and lustre.



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9-51

MULTI-CLEAN
PRODUCTS, INC.

NEWS...

Tri State Hospital Assembly Totals 7500

(*Continued From Page 58*)

often required to pay for expensive research and education programs which should properly be supported from other sources.

Scoffing at the belief of some specialty groups that every physician must be compensated on a fee-for-service basis, Dr. Moore asked if it was contemplated that the pathologist should "send a bill for every urinalysis." Under a rigid fee-for-service system, he said, the physician would be charging for many services actually performed by technicians.

In a rapid-fire, informal talk that ranged over the whole area of hospital staff operations, Dr. Moore also pointed out:

1. That hospitals could get credit (toward accreditation) for coroner's postmortems by having an intern in the room with the coroner's pathologist taking notes, getting sample tissues for examination, and making a report to the hospital staff.

2. That the administrator should attend every meeting of the hospital's medical staff.

3. That "we're exploiting the resident and intern, who is now being pauperized." These staff members should be paid, and "the doctors should pay. If they didn't have interns and residents they would have to curtail their practice 50 per cent." The intern and resident do not serve the hospital, Dr. Moore added. They serve the doctor primarily.

"COLLECTION OF KINGDOMS"

Addressing the same meeting, Huntington Henry, president of St. Luke's Hospital, Chicago, had defined the hospital as "a collection of little kingdoms." Each kingdom, he explained, is motivated by self-interest. "When these kingdoms and their rulers are in agreement, we have a smoothly operating institution," Mr. Henry said. "But when one of these groups has a falling-out with any other, trouble occurs. So it is important that a trustee be skilled in the fine art of human relations. It is also important that he acquire the great gift of remaining impersonal and objective at all times. It is, without qualification, the most exacting and complex job in the entire fabric of social welfare organizations."

In a Monday evening free-for-all, the 34 chairmen of the Tri-State Assembly sections, covering everything from accounting to x-ray, competed, under the fierce cross examinations of judges Hamilton and Buerki, for a prize in "obtaining efficiency in each department to improve the care of the patient." Winner—as much for her dexterity in dodging the slings and arrows of the judges as for efficiency in patient care—was Mrs. Madge H. Sidney of the Evanston Hospital, the housekeepers' champion. Mrs. Sidney's formula: Make hospital housekeeping a respectable, desirable career by establishing educational programs and standards, helping housekeepers obtain education, encouraging the development of new technics. In reply to persistent questioning from the judges about the salaries that would have to be paid to qualified housekeepers under such a program, Mrs. Sidney refused to be pinned down and insisted that "the

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Among these Standard Brands products a truly outstanding favorite is, of course, the famous Chase & Sanborn Fancy Mark Coffee. When *you* serve Fancy Mark Coffee *you* can be sure each meal will end on a note of real enjoyment. *You'll* find, also, that *every* Standard Brands product can make a real contribution to your food service. What's more, top-quality Standard Brands products cost no more—often less!—than most ordinary products.

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P-24

trained housekeeper will save her salary many times over."

WOMEN'S AUXILIARY

Tuesday was red letter day in the Red Lacquer room for 300 alert auxilians. These women looked snappy both in dress and in deeds.

Program Chairman Mrs. Cecil D. Snyder of Kenosha, Wis., provided preluncheon and postluncheon fare of wide variety—speeches, panels and projects galore. A hotel luncheon is a hotel luncheon, but James A. Hamilton spiked the coffee and dessert with aphorisms and anecdotes. The director of the Program in Hospital Administration at the University of Minnesota urged hospitals and volunteer organizations to provide the individual volunteer with an advancement program so that her interest and her efforts may constructively develop.

The audience liked the story told by Mrs. John A. Bigler of Highland Park Hospital in Illinois. It was the story of an aged and ailing auxiliary and how it reacted to something in the nature of hormone injections. At any rate it started to rejuvenate four years ago, and now out of its 650 members there are 450 active volunteers within the hospital or at work on hospital projects.

SMALL HOSPITALS

Setting the stage for small hospitals (with projector and slides at one end of the Grand Ballroom and screen at the other), Dr. Martha O'Malley, director of the division of hospital and institutional services, Indiana State Board of Health, considered the changes within the hospital that have emerged over the years, and especially since the war, with respect to type of patient and personnel demands. The changes which have evolved resulted in problems of organization and management, which in turn brought problems of understanding, she explained. Through the medium of about a dozen slides, every phase of organization from planning to the completed organization was shown.

Quality was the cry of Olive M. Murphy, administrator of Bartholomew County Hospital, Columbus, Ind. Good department heads, she explained, are a bargain when they are able to take an effective part in the total hospital operation by maintaining and coordinating authority within the department, and seeing to it that they surround themselves with people who can fill needs before the needs become known.

Bringing specialists into the act, Miss Murphy saw a place in the small hospital for radiologists, pathologists and physical therapists. She also considers a recovery room a "must" for the small hospital.

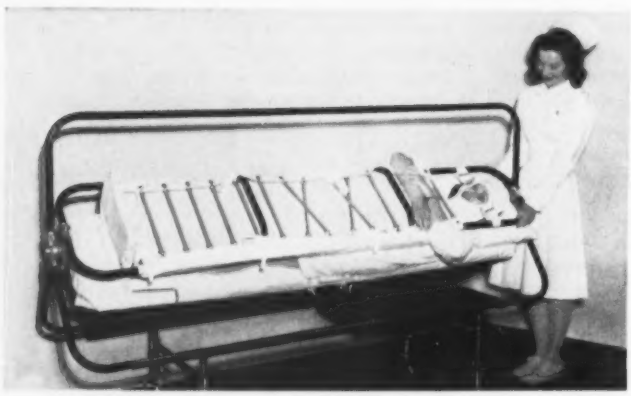
"Pray like all depends on God and work like all depends on you," J. Gordon Dandignac, administrator, Dickinson County Hospital, Iron Mountain, Mich., advised all persons concerned with the equipping of small hospitals. He listed the areas a purchasing agent should concern himself with and described procedures for determining equipment needs.

Lowest possible cost of medical care came up for consideration next. Kenneth K. Moburg, administrator of Schoolcraft Memorial Hospital, Manistique, Mich., said the economic life of a small community hospital was de-

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In immobilization, the smallest nurse can turn the largest patient with utmost ease and safety.



A new development in the treatment of immobilized patients, the Stryker Turning Frame is essential equipment for the modern hospital. While held gently but firmly between the two frames of this unique device, any patient can be quickly turned by one nurse. One frame is removed after turning, and the other, covered with taut canvas and pad, provides a smooth, comfortable resting surface. Lying on the anterior frame, the patient can read, write and feed himself with ease. In cases of pelvic, intertrochanteric or cervical fractures, either end of the frame can be elevated to provide continuous traction throughout the turning process. Built of the finest materials, and widely accepted by orthopedists, gynecologists and neuro-surgeons, the Stryker frame saves valuable nursing time and increases the comfort and well-being of the patient.

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No. 809 36" and 54" widths — .004 thickness — 25 yd. rolls . . . clear or opaque.

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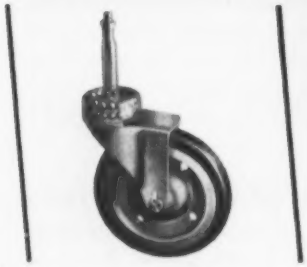
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NEWS...

pendent on its utilization by all the physicians in its community. Two other outstanding factors that make the difference between profit and loss are adequate rates and charges, and voluntary health insurance.

Western Hospitals Get the Wright Treatment

(*Continued From Page* 56)

picture in front of some greenery in the elevator lobby, but he declined. "It's artificial," he said with a shudder.

Stung in some sensitive spots by Mr. Wright's abrasive treatment, administrators were quickly given a soothing lotion by two experienced practitioners, Prof. James A. Hamilton of the University of Minnesota and Dr. John W. Cline of San Francisco, past president of the American Medical Association. Peering into the future, Professor Hamilton foresaw an era of expanding hospital care in an expanding economy, with more people making greater use of hospital facilities and a diminishing gap between advancing medical science and the application of its benefits to larger groups in the population. With "third party purchases" of medical and hospital care increasing, he predicted, buyers will be more critical than they have been in the past, and so the trend must be toward economy through integration of services and facilities, instead of toward the decentralization cherished by Mr. Wright. Referring to corporations, unions and other contracting agencies, Professor Hamilton warned: "These groups are intolerant and impatient of controversies within our professions." To minimize controversy, Dr. Cline recommended, reach the doctors during their hospital staff meetings to tell them about the hospital's problems.

At another general session, the convention entertained another visitor from outer space, or, more accurately in this case, the utilities industry. In an address that was thoughtfully developed and brilliantly presented, Adam S. Bennion, vice president of the Utah Power and Light Company, told administrators that knowledge of psychology and sociology is necessary to an understanding of human behavior—one of six faculties which he said the successful administrator must have. Others were:

1. Know the business. The administrator should know more and be learning more than anybody else in the business.

2. Know enough accounting to be able to prepare, understand and explain the balance sheet. Its accountants are the "eyes of an institution."

3. Be "anchored to sound economic principles and effective in raising funds."

4. Be "a master of the art of communication"—able to evoke not only understanding but desired responses from employes, trustees and the public.

5. Be "a champion of all the things which we identify as peculiarly American."

The job of the executive in our society is getting bigger and tougher all the time, Dr. Bennion said, as our organizations and institutions become more complex. Interest in scientific management is one of the most stimulating things in the United States today, he added. Good management is the key to success or failure of a business or institution, he said.

Response to Dr. Bennion's talk was uniformly favorable — a circumstance that is rare enough to suggest that hospital conventions might systematically look outside as well as inside for advice. Providing a neat switch on this suggestion, the advice that came from one insider could be given with equal cogency to hospital administrators, public utilities executives or locomotive salesmen: "Think about long-term goals as well as daily tasks," Dr. Arthur C. Bachmeyer, now director of the Commission on Financing Hospital Care, insisted, elaborating on a principle that was once expressed, in terms that were widely misunderstood, by Beardsley Ruml, the pay-as-you-go tax man who is now treasurer of Macy's. Ruml said that any executive who didn't spend at least half his time doing nothing but thinking was probably wasting his employer's money.

Dr. Bachmeyer was more explicit, and less likely to be misinterpreted as having recommended daydreaming, if not downright loafing: "The administrator should keep the larger view constantly in mind," he said. "Think about the attainment of goals and the hospital's place in society, not merely about your daily tasks." The successful administrator is constantly analyzing the purposes and objectives of his institution, Dr. Bachmeyer explained, because "the best organiza-



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tions today may not be the best tomorrow."

Among the most important hospital problems of the future, Dr. Bachmeyer named relations with the medical staff—and, especially, the need for a better understanding of the hospital by the staff. "Costs are always a secondary consideration to the clinician, who has no training in economics," he explained. It is up to the administrator to train doctors in the economics of hospital operations, he said. "We must make them understand the impact of medical practice on hospital costs," he concluded. To meet the increasingly complex and challenging problems of the future, Dr. Bachmeyer said, the administrator will need greater knowledge, greater skill and greater competence as time goes on.

The kind of administrator Dr. Bachmeyer and Dr. Bennion were talking about is made, not born, and the thing that makes him today is education, according to Ray Brown, administrator of the University of Chicago Clinics, who emphasized the difference between technical training and real education. It is easy to teach the technical aspects of administration, accounting, personnel and other subjects, Mr. Brown said, but those who want to see hospital administration become a profession are not satisfied with teaching facts. They want to teach the "why" as well as the "how"—including the theory or principles by which we determine whether procedures and results are good or bad.

Mr. Brown distinguished sharply between technical knowledge, on the one hand, and a broad understanding of the disciplines that help us to judge our society. We are not educating our hospital administration students when we teach them the number of square feet of wall space that can be cleaned in an hour, or the number of pounds of laundry that should be turned out in one shift, he said. "The student with the broadest general education usually wants these things the least," he pointed out. Instead, Mr. Brown suggested, the course in hospital administration should include as much basic science as one year can encompass and then teach the purpose of the hospital and its uniqueness in our society. "A broad understanding of industrial relations plus an understanding of the uniqueness of the hospital is better than a course in hospital personnel relations," Mr. Brown explained.

The day-to-day decisions of the administrator emerge from a "repertory of convictions" that he has formed over his entire lifetime, Mr. Brown suggested. These convictions emerge from the administrator's knowledge, prejudices, theories and principles, he explained. By teaching basic sciences and the theory and philosophy of the voluntary hospital in our society, he said, educators can help mold the students' convictions in the direction of right decisions.

It is the quality of his convictions and his grasp of right principles that measure the stature of an administrator, and not the size of his hospital. This was implicit in Ray Brown's address and apparent in a meeting of the convention's Community Hospital Section, where administrators of hospitals ranging down to nine beds in size wrestled with problems involving





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NEWS...

precisely the same principles that mold decisions at Latter-Day Saints and Los Angeles County. Reporting to the convention on the year's activities of the section, Chairman John Gorby of La Mesa, Calif., described a series of lectures that has been developed especially for administrators of small hospitals and presented at institutes and conventions sponsored by state hospital associations in the western area. Eventually, it is planned, the lectures will cover as many as 40 separate subjects. During the last year, Mr. Gorby explained, the first seven or eight lectures have been developed and presented.

Several of the lectures, covering such subjects as medical service audits, clinical pathological conferences, discharge practices, and commercial health insurance, were presented in the section meetings, just as they have been presented earlier at institutes and state conventions. Each lecture was organized around a series of specific questions, and in each case a list of the questions was passed around to members of the audience before the lecture began—a happy practice that kept listeners informed of where they were in time and space and made note-taking easier for reporters.

In other section meetings, hospital executives heard and took part in discussions covering business practices, nursing, food service, housekeeping, laundry, pharmacy, purchasing and other hospital problems. Meeting in a separate conference before the convention opened, the western conference of the Catholic Hospital Association of the United States and Canada heard addresses by the Rt. Rev. Msgr. Charles A. Towell, president of the Catholic Hospital Association, and Sister Mary Aquilina, administrator of St. Mary's Hospital, St. Louis. Msgr. Towell and Sister Aquilina discussed the need for expanding psychiatric facilities in general hospitals and the problems attendant on operation of psychiatric units.

Graduates Anesthetists

SPRINGFIELD, ILL. — Graduation exercises were held at St. John's Hospital here on April 26 for seven registered nurses who completed their course in anesthesiology. Nine registered nurses entered the new class on May 1.

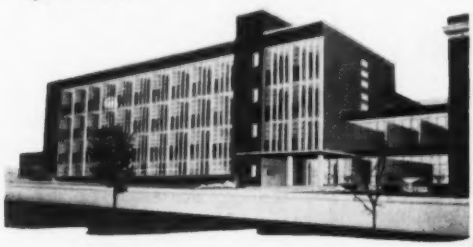


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Back Row, Left to right: E. M. Collier, administrator, Hendrick Memorial Hospital, Abilene—trustee; D. S. Riley, administrator, Malone and Hogan Clinic-Hospital Foundation, Big Spring—trustee; H. R. Dickey, administrator, Driscoll Foundation Children's Hospital, Corpus Christi—trustee; Boone Powell, administrator, Baylor University Hospital, Dallas—treasurer; J. Richard Gates, administrator, Ragland Clinic-Hospital, Gilmer—trustee; T. H. Morrison Jr., administrator, Valley Baptist Memorial Hospital, Harlingen—trustee.

Front Row, Left to right: John G. Dudley, administrator, Memorial Hospital, Houston—president-elect; W. U. Paul, administrator, Southwestern General Hospital, El Paso—president; Carroll H. McCrary, administrator, Medical and Surgical Clinic-Hospital, Tyler—immediate past president; H. M. Cardwell, administrator, Memorial Hospital, Lufkin,—vice president. Sister M. Adele, R.S.M., Mercy Hospital, Brownsville, was elected president of the Texas Conference Catholic Hospital Association, which met concurrently with the Texas Hospital Association.

Mrs. Josie M. Roberts, former administrator of the Methodist Hospital in Houston was unanimously elected to honorary life membership.



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Practical Nurse Educators Praised by Dr. Kogel, Others

NEW YORK.—From state associations and from 200 schools of practical nursing came some 500 delegates to the annual convention of the National Association for Practical Nurse Education held here May 4 to 7.

The practical nurse educators heard messages sent them from President Eisenhower and Governor Dewey and a speech delivered by Dr. Marcus D. Kogel, commissioner of hospitals.

"I doubt that anyone is in a better position than I am to attest to the tremendous contribution made by the trained practical nurse to hospital nursing services," Dr. Kogel told the delegates. "Today there are 2370 practical nurses working in all our hospitals and they are respected members of the nursing team. Their effectiveness has been increased through continuous staff education programs and careful assignment of duties that utilize their skills to the maximum.

NEED MANY MORE

"We could not have provided adequate care for patients in existing hospitals, let alone staff our new facilities, without the valuable contribution of practical nurses. In the most recent addition to the Department of Hospitals, the Bird S. Coler Hospital for the Care of Chronic Diseases, practical nurses can assume a major share of the nursing care of patients. We still need many more in this and in other hospitals."

Other speakers included Anna Fillmore, director of the National League of Nursing; Dr. Leo W. Simmons, department of sociology, Yale University; Mrs. Brahna C. Hutchins, dean of women, Carnegie Institute of Technology, and Raymond N. Hatch, Institute of Counseling, Testing and Guidance, Michigan State College.

Mildred L. Bradshaw, director of nurses, Leigh Memorial Hospital, Norfolk, Va., was reelected president of the association. Joseph V. LeRoy and Ella M. Thompson, both of New York City, were reelected vice president and secretary, respectively.

Four new members of the board of directors were named: the Rev. John J. Flanagan, S.J., of St. Louis; Kathryn S. Goodman of New York City; Mrs. Charles A. Newhall of Boston, and Mildred H. Smith of Springfield, Ohio.

Next year's convention will be held in San Antonio, Tex., May 1 to 4.

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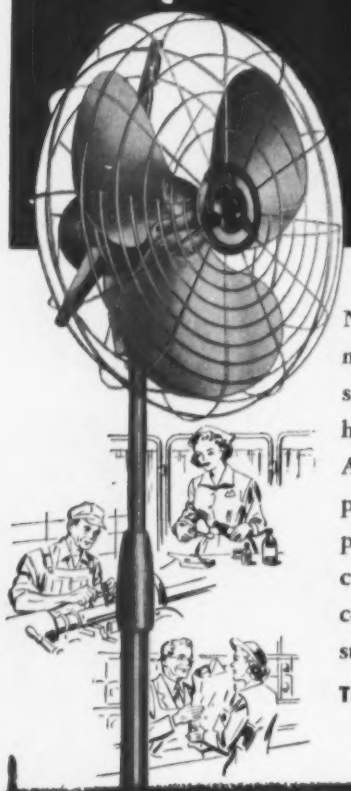
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NEWS...

Upper Midwest Meeting Tries New Program Plan

(*Continued From Page* 140)

to give a more nearly accurate record of oxygen used in oxygen therapy; special medication dispensing carts, and cabinet rackholders for sterilizing hypodermic needles and syringes.

This year's Nellie Gorgas Memorial Lecture was given by James A. Hamilton, professor of hospital administration, University of Minnesota. In opening his lecture, Mr. Hamilton asked, "Where are we now and where are we going in the hospital field? Changes and advances in medical science and practice," said Mr. Hamilton, "will force us to reevaluate our whole program. The increasing amount of work being done on the prevention of disease will change our whole concept of hospital design and function."

Mr. Hamilton predicted increasing specialization within the ranks of the medical profession and said that this trend will force a great increase in group practice medicine centered around and in hospitals. This is likely to mean that doctors will concentrate all their practice in one hospital rather than divide their time among several. Patients will go to the general practitioner in the group practice clinics much as they now go to their family physician. This general practitioner will guide the patient through the group practice clinic to various specialists and finally interpret the results of their study to the patient, Mr. Hamilton said.

In discussing the economics of medical and health care in the future, Mr. Hamilton said that a larger percentage of the consumer's income will go for health care and with this will come a higher level of health and better standards of medical and hospital care in this country. "We should stop apologizing for our increasing hospital costs and start boasting about our new services and higher standards," said Mr. Hamilton. "True economies in medical and hospital care can and will be effected by stopping abuses such as the overuse of hospital facilities and the carrying out of unnecessary procedures. Social groups will replace the individual as the payer and the provider of organized medical and hospital care," Mr. Hamilton said.

(*Continued on Page* 181)

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NEWS...

(*Continued From Page* 178)

Thursday morning's general session was devoted to "Dynamic Learning Technics." Speakers were Howard P. Mold, director of training, and Gerry Morse, vice president in charge of industrial relations, Minneapolis Honeywell Regulator Company. The afternoon session was devoted to "Third Party Payments" and discussions were led by Mr. Swanson and Albert V. Whitehall of the A.H.A.'s Washington Service Bureau. All the thinking at this general session was directed to the fact that federal, state and local units of government must pay on a full cost basis for indigent patients coming under their legal responsibility.

Kenneth Holmquist, administrator of the Minneapolis General Hospital, in discussing hospital relations with labor unions, said, "Labor and labor leaders assume great responsibility for the community's health when they become an influential force in the policies of our hospitals. There are no indications, at least in this area, that the unionization of hospital workers will diminish," Mr. Holmquist stated.

Continuing the discussion, he pointed out that union labor-hospital relations means a new concept of the administrative function in hospitals. He further pointed out that much more attention must be paid by administrators and supervisors at all levels to the thoughts, desires and ambitions of each individual employe.

Ample time was provided between the hours of 11 a.m. when the morning's sessions closed and 3 p.m. when the afternoon sessions opened for the approximately 3400 registrants to view the exhibits of 97 different concerns in the exhibit hall. These exhibits were in reality a continuation of Wednesday morning's opening session.

Louis B. Blair, superintendent, St. Luke's Methodist Hospital, Cedar Rapids, Iowa, was elected president of the Upper Midwest at the annual business meeting. J. M. McIntyre, secretary-manager, Winnipeg Municipal Hospitals, Winnipeg, Man., who during the year had been appointed vice president to fill a vacancy, was elected to the vice president's post for the full ensuing year.

COMING EVENTS

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Institute on Hospital Accounting, Indiana University, Bloomington, July 12-17.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Palace Hotel, San Francisco, Oct. 5-9.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Conference on Human Relations, Sheraton Hotel, Detroit, June 8, 9.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, San Francisco, Aug. 31—Sept. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 18-21.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Baker Hotel, Dallas, Tex., June 15-19.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, Royal York Hotel, Toronto, Ont., June 28-July 2.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Mar Monte, Santa Barbara, Oct. 29, 30.

COLORADO HOSPITAL ASSOCIATION, Antlers Hotel, Colorado Springs, Nov. 19, 20.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 3, 4.

INSTITUTE ON ANESTHESIA, Somerset Hotel, Boston, June 22-26.

INSTITUTE ON DIETARY DEPARTMENT ADMINISTRATION, Park Sheraton Hotel, New York City, Oct. 26-30.

INSTITUTE ON HOSPITAL PHARMACY, Loyola University, Los Angeles, June 15-19.

INSTITUTE ON HOUSEKEEPING, Somerset Hotel, Boston, Nov. 16-20.

INSTITUTE ON LAUNDRY, Park Sheraton Hotel, New York City, Nov. 9-13.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, St. Charles Hotel, New Orleans, Dec. 7-11.

INSTITUTE ON PHARMACY, Loyola University, Los Angeles, Aug. 24-28.

INSTITUTE ON PUBLIC RELATIONS, Princeton University, Princeton, N.J., June 29-July 3.

INSTITUTE ON PURCHASING, Penn Sheraton Hotel, Philadelphia, Oct. 19-23.

INSTITUTE ON SUPERVISORY TRAINING, Edgewater Beach Hotel, Chicago, Nov. 2-6.

INTERNATIONAL CONSUMER CREDIT CONFERENCE, New Orleans, June 22-26.

KANSAS HOSPITAL ASSOCIATION, Lassen Hotel, Wichita, Nov. 12, 13.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Nov. 9, 10.

MISSISSIPPI HOSPITAL ASSOCIATION, Buena Vista, Oct. 14-16.

NATIONAL LEAGUE FOR NURSING, Biennial Convention, Statler Hotel, Cleveland, June 22-26.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 12, 13.

WASHINGTON HOSPITAL ASSOCIATION, Olympic Hotel, Seattle, Sept. 30-Oct. 1.

1954

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.



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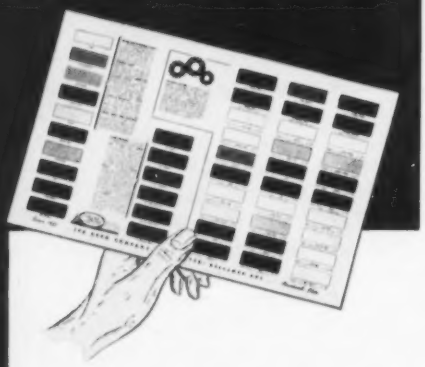


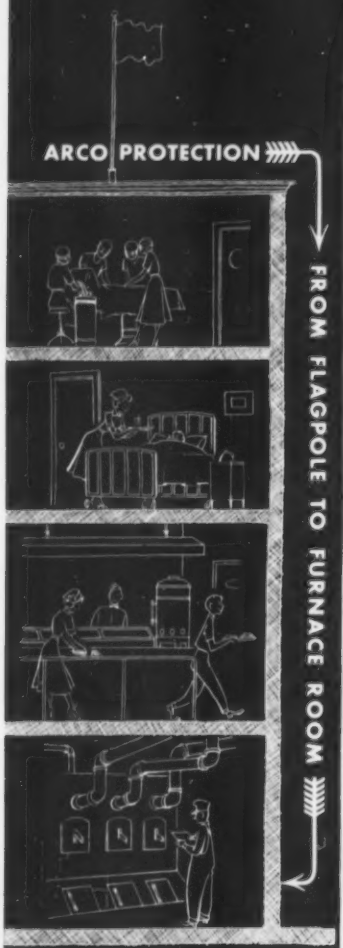
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NEWS...

Sister M. Bernardine Heads North Dakota Association

(*Continued From Page* 140)

Jonz, a laundry specialist, and Mr. Thielman, chief engineer of St. Joseph's Hospital, Dickinson.

Sister Gertrudis emphasized the importance of cooperation from the organized medical staff if medical records are to be put in condition to meet the approval requirements of the Joint Commission on Accreditation of Hospitals. Many questions concerning various means to reduce costs were asked, and the participating panel members had practical suggestions to offer. Mr. Thielman, the engineer, emphasized the importance of all department heads' cooperating with the engineering and maintenance department so that minor difficulties can be corrected before they develop into major mechanical repair jobs.

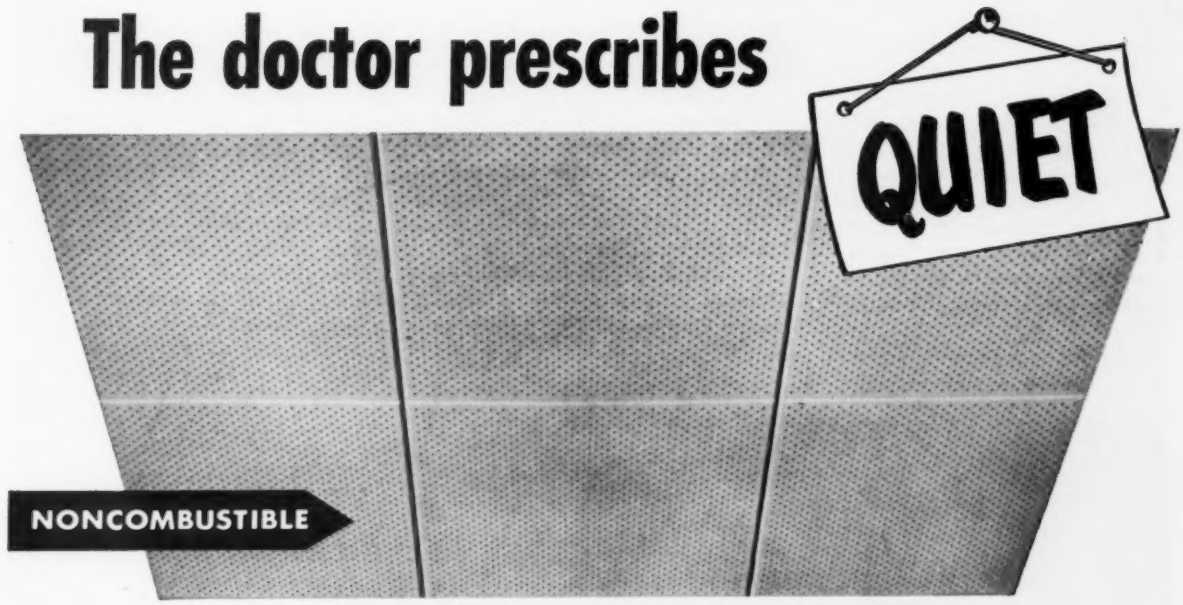
Mr. Jones made the point that the major possibility of saving the public's money lies in the direction of the elimination of unnecessary hospitalization and of the carrying out of unnecessary procedures during the patient's stay.

Warren W. Larson, credit manager and business manager of the Deaconess Hospital, Grand Forks, in discussing credits and collections, said: "The biggest problem in collection is the failure to get full information before or during the patient's stay in the hospital. Proper procedures and methods during these two periods will cut collection problems by 50 per cent."

The afternoon session featured a joint meeting of women's auxiliary members and hospital administrators and department heads, also moderated by Mr. Jones. The discussants included Mrs. Palmer Rusted of Williston, Mrs. A. R. Brooks of Hazen, and Mrs. Samuelson of Turtle Lake, newly elected president of the state auxiliary.

Mrs. Samuelson urged that women's groups in any community be brought into the first talking and planning stage for a new hospital. "You must arouse the women's interest from the very beginning if you want their continuing interest and help," she said. Mr. Jones pointed out that members of the women's auxiliary must be kept fully informed by a hospital administrator so that they, in turn, can interpret the hospital to the community. "It is equally important," said Mr. Jones, "for members of the auxiliary to interpret com-

The doctor prescribes



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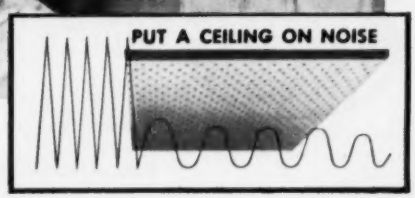
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munity opinion to the hospital administrator."

A session on Tuesday evening following the annual banquet featured a clinic on small hospital problems. Sidney Berhow of Williston was the featured performer at this evening session. His humorous and philosophic discussion of the problems facing administrators in small hospitals was centered on medical staff-hospital administrator relations.

At Wednesday morning's session, the delegates heard Beth Harrington, hospital inspector for the state department of health, discuss the ever increasing interest of hospital administrators and trustees in raising standards.

"Hospital administrators and trustees are increasingly realizing their responsibilities to the community," Miss Harrington said. She outlined the great improvement in physical facilities in hospitals in North Dakota and singled out the elimination of fire hazards and of operating room explosion hazards and dishwashing sanitation as among the many improvements she had noticed. She emphasized the need for great improvement in medical records.

Dr. O. D. Johnson, president of the North Dakota Medical Association, addressed the convention on the subject of relationships among hospital administrators, doctors, dentists, pharmacists and nurses. Dr. Johnson declared: "The shortcomings of the medical profession, and they are many, must be openly and fully discussed by liaison groups representing hospital trustees and administrators and their organized medical staffs." He praised the efforts being made by many state medical and hospital associations in improving understanding and relations between hospital administrators and their professional staffs.

Following Dr. Johnson's talk, Mr. Jones discussed the economic and moral aspects of professional practice in the hospital. He stressed the legal and moral responsibility of every hospital trustee and administrator for the standards of medical care afforded hospital patients. "Realistic, regular, honest medical audits and a hard-working surgical tissue committee are the keystones of improved medical and hospital standards," remarked Mr. Jones.

Donald E. Eagles, head of the North Dakota Blue Cross and Blue Shield Plan, moderated a session on Blue Cross stressing the importance of real community and consumer representation on the Blue Cross and Blue Shield governing board. The feature of this session was the talk on the future of Blue Cross by Sister Elenius of Minot, who maintained that everyone in the hospital field must be interested in Blue Cross and help promote it if he wants to guarantee the financial stability of hospitals. "We have no part in making the policies of commercial insurance plans, whereas we help guide and make Blue Cross policies," said Sister Elenius. "When we protect the assets of our Blue Cross plans against abuse, we are in fact protecting the assets of our own hospitals and safeguarding the public's money," she said.

Sister Elenius pointed out that Blue Cross managers must get over the idea that their plans will sell themselves and must train good salesmen to get out and sell hospital administrators, trustees, staff doctors, and everybody in the community on the great benefits of Blue Cross.



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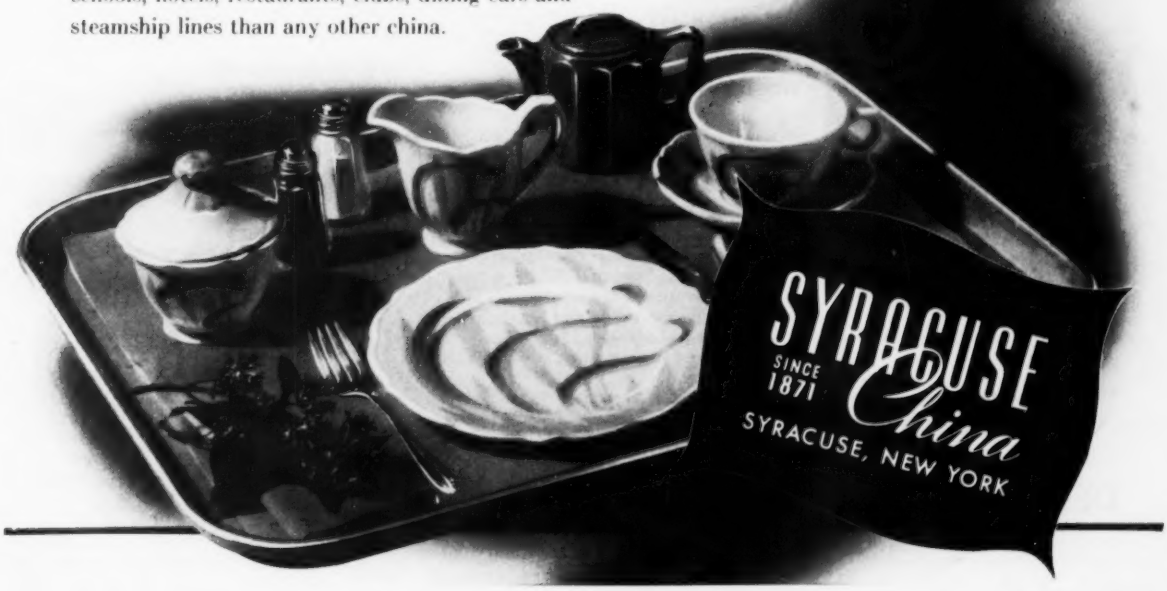
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NEWS...

City Home Evacuated

NEW YORK.—Eleven hundred and eighty-five aged and infirm patients of the New York City Home for Dependents on Welfare Island evacuated the building last month to move either to the new five-story brick Bird S. Coler Memorial Hospital and Home, also on Welfare Island, or to the city-owned Farm Colony on Staten Island.

A group of 330 patients who need hospital care has been moved from the Farm Colony to Coler Memorial Hospital and patients from Coler who are well enough for life at the Farm Colony have joined others from the City Home there.

Polio Work Conferences Prepare Nurses for Epidemic

NEW YORK.—Twelve 10 day work conferences on nursing the polio patient were held during late April and May to prepare the nursing personnel of the entire nation for the predicted 50,000 cases of poliomyelitis expected to occur this year.

Two work conferences were held in each of six regions. The purpose was to prepare key personnel to conduct similar work conferences in their own communities so that as many nurses as possible can act as supervisors and teachers in the event of an epidemic.

The conferences were cooperatively sponsored by the National Foundation for Infantile Paralysis, the National League for Nursing, the state leagues, and local universities.

Diagnosis of Polio Speeded by Discovery

ATLANTA, GA.—A cheaper and faster method of diagnosing poliomyelitis has been discovered by two research workers in the Public Health Service's communicable disease center, national headquarters here announced last month.

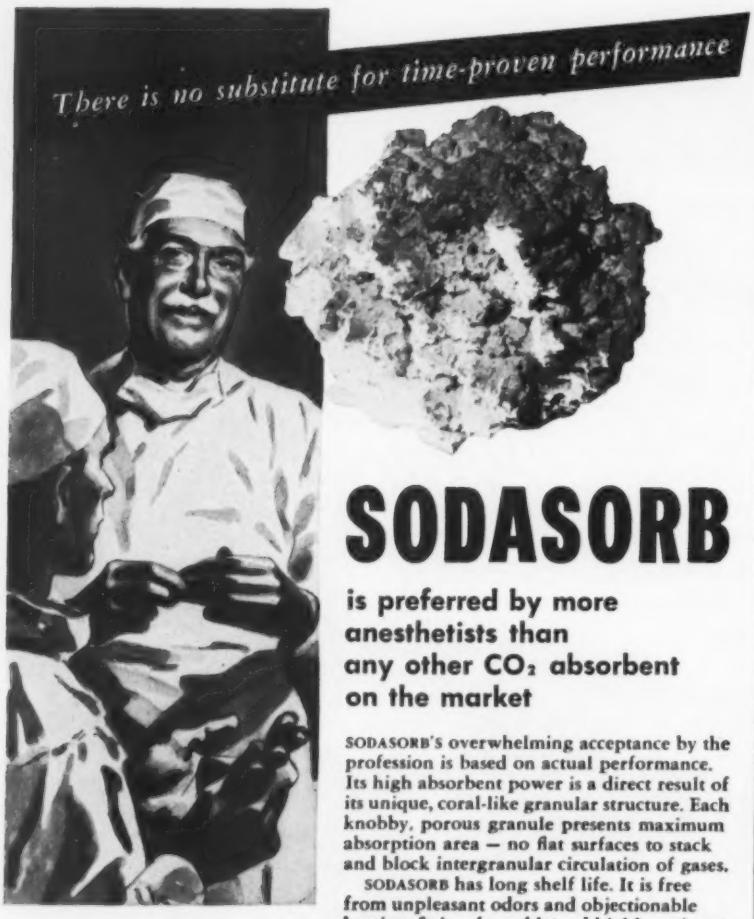
The two government scientists have developed a virus from mice that will speed diagnosis and may lead to an improved vaccine against the disease. Dr. C. P. Li and Dr. Morris Schaeffer of the Virus and Rickettsia Laboratory, Montgomery, Ala., made the discovery.

Heretofore, polio research has been retarded by the necessity of using monkeys and chimpanzees, which are more expensive and more difficult to work with than are mice. For this reason researchers have been trying to cultivate the polio viruses in other animals or in the test tube.

The Public Health Service believes that the discovery may lead to the development of a "live" virus vaccine against the disease, which might be effective for a year. The only immunizing agent now in use, gamma globulin, is effective for about five weeks only.

Gamma globulin, which is a human blood derivative, will be available only in "sharply limited" amounts this year. This preventive, which was tested in 1951 and 1952 in several communities, will for the most part be available only for members of the household of proved polio cases. Those under 30 years old and pregnant women of all ages will have first call on the supply for households.

The nationwide pool of gamma globulin is being allocated by the Office of Defense Mobilization. The



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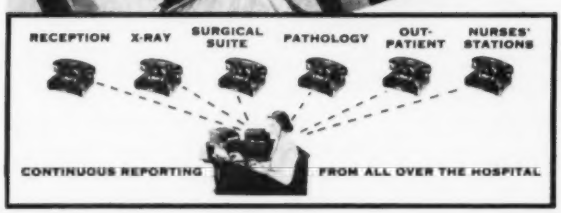


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NEWS...

American Red Cross, which obtains blood from donors, and the National Foundation for Infantile Paralysis, which has bought all commercial supplies, have turned over their supplies to the Office of Defense Mobilization. The first allotment was made to the states last month; it is based on the average annual number of polio cases in the years 1947-51.

ABOUT PEOPLE

(*Continued From Page* 85)

Preston L. Hill has been named administrator of the 54 bed Lucius O. Crosby Memorial at Picayune, Miss., which will be constructed to replace the present Martin Sanatorium.

William N. Gregg has been named manager of the Veterans Administration Center at Wadsworth, Kan., succeeding **Homer Rogers.** Mr. Rogers was appointed manager of the V.A. Center at Bay Pines, Fla.

Velma Stewart, R.N., will retire July 1. Miss Stewart has served for many years as administrator of North Mississippi Community Hospital, Tupelo, Miss., and will be succeeded by **T. Ray Jones,** who is completing his term of administrative residency at the Methodist Hospital, Memphis, Tenn.

Dr. Frank L. Jennings, for the last 15 years superintendent at Sunnyside Sanitarium, Indianapolis, has resigned to become chief of professional services at the Veterans Administration Tuberculosis Hospital, Indianapolis, now under construction. **Dr. C. H. Smith,** present manager of the V.A.'s Billings Hospital, Fort Benjamin Harrison, will be manager of the new tuberculosis hospital, which will replace Billings Hospital.

C. A. Miller is the new director of Loma Linda Sanitarium and Hospital, Loma Linda, Calif., where he had formerly served as credit manager. Mr. Miller, who has had 17 years' administrative experience in business and financial affairs, succeeds **John H. Nies,** who resigned because of poor health.

William Winston, for the last six years administrator of Ivy Memorial Hospital, West Point, Miss., has resigned his position to accept a position with the Mississippi Hospital and Medical Service in Jackson, Miss.



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Medical Products Division

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Harry Cutler, former administrator of Okolona Community Hospital, Okolona, Miss., has been named Mr. Winston's successor.

F. J. Picknell, formerly administrator at Monroe Hospital, Monroe, Mich., has resigned to accept a similar position at Guernsey Memorial Hospital, Cambridge, Ohio.

Samuel Zibit has been appointed assistant director of Mount Sinai Hospital of Greater Miami, Miami Beach, Fla. Before accepting this appointment, he had served in a similar capacity at Miriam Hospital, Providence, R.I.

Maj. Gen. Joseph I. Martin, deputy commanding general and commandant of the Medical Field Service School at Fort Sam Houston, Tex., has been named commanding general of the Brooke Army Medical Center there. Gen. Martin will take over after the retirement of **Maj. Gen. Edward A. Noyes.**

Thomas Hagen, formerly superintendent of Trinity Hospital, Minot, N.D., has accepted an appointment as superintendent of both the new Bethesda Hospital at Crookston, Minn., and the old hospital which will be a rest home. Mr. Hagen assumed his new position May 1.

L. Brent Goates has been appointed assistant administrator at Latter-Day Saints Hospital, Salt Lake City, Utah. Mr. Goates is a former newspaper man and was graduated from the University of Utah in 1949 with a B.S. degree in marketing and business management.

M. J. Thompson, administrator of Blanchard Valley Hospital, Findlay, Ohio, for the last seven years, has been appointed administrator of Dettmer Memorial Hospital at Troy, Ohio, now under construction. Mr. Thompson began his hospital career at Ball Memorial Hospital, Muncie, Ind., working in charge of stores and as purchasing agent, and from there moved into an assistant administratorship at Youngstown, Ohio, before going to Blanchard.

Dr. Charles D. Feuss Jr. and **Dr. G. P. Wyman** have been named heads of two of Kentucky's four mental hospitals. Dr. Feuss has been appointed acting superintendent of Eastern State Hospital at Lexington, Ky.; Dr. Wyman becomes superintendent of Central State Hospital, Lakeland, Ky.

Dr. Floyd K. Foley, superintendent of Western State Hospital, Hopkinsville, Ky., will retire July 1 because of ill health. When Dr. Foley recovers, he plans to resume part of his duties and serve as a consultant while a new superintendent is learning the hospital operation. Before coming to Western State Hospital he was senior physician at the Veterans Administration Hospital, Lexington, and superintendent of Eastern State Hospital.

Talmadge H. Lewis is the new administrator of the Olathe Community Hospital, Olathe, Kan., which is scheduled to begin operations by September 1. Mr. Lewis served as administrative resident at Bethany Hospital, Kansas City, Kan., as part of his postgraduate training from Washington University, St. Louis, toward completion of his master's degree in hospital administration, which he expects to receive this month.

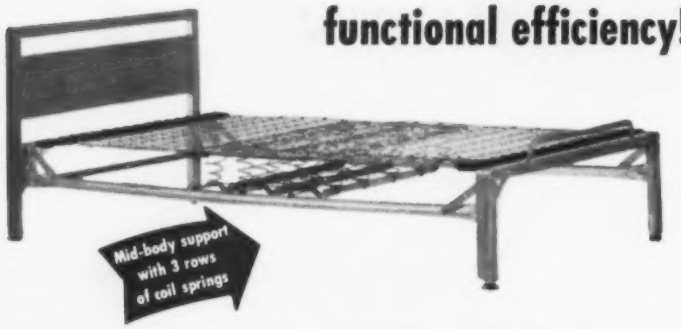
George W. Laycock recently became administrator of the Conway Hospital, Conway, S.C. Serving the hospital field in various capacities, he has held administrative positions both in China and the United States. In 1951 Mr. Laycock became general hospital administrator of the trust territory of the Pacific Islands, where he was in charge of personnel, purchasing and policies for six hospitals under United Nations sponsorship.



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Gerald C. Crary has been named acting administrator of Scripps Memorial Hospital, La Jolla, Calif, succeeding **Frank L. Guchereau.** Mr. Crary has served on the hospital's board of trustees and was president of the board during the 1950-51 term.

F. H. Silversides, formerly superintendent of the Children's Hospital, Winnipeg, has been appointed superintendent of the Children's Hospital, Halifax, N.S., succeeding **Dr. J. L. Sutherland.** Mr. Silversides is a graduate in pharmacy from the University of Manitoba and a graduate of the hospital administration course at the University of Toronto.

Mildred F. Walker, has joined the administrative staff of the Memorial Hospital Association of Kentucky, Washington, D.C., as an associate administrator under the direction of **Gordon A. Friesen,** senior hospital administrator. Miss Walker has served as consultant in the Children's Bureau of the Federal Security Agency, where she was instrumental in the development of the cost method of payment for hospital care under the E.M.I.C. program and was active in the third-party payment conferences sponsored by the American Hospital Association.

Warner Kass, administrator of Franklin County Memorial Hospital, Meadville, Miss., has accepted a similar position in California.



G. B. Little Jr.

George B. Little Jr. has been appointed administrator of the Children's Medical Center at Dallas, Tex. Prior to this appointment, Mr. Little served an administrative residency at Baylor University Hospital.

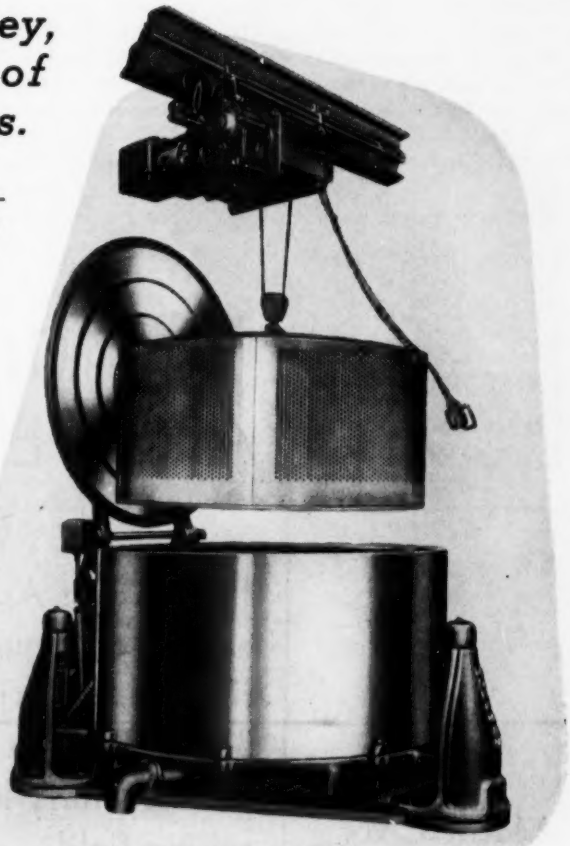
William Montgomery has resigned his position as business manager of Coahoma Clinics and Hospital, Clarksdale, Miss. No successor to Mr. Montgomery has been named yet by **Reed Hogan,** administrator of the hospital.

Harry L. Miller is the new director of Sara Mayo Hospital, New Orleans, succeeding **Dr. Louise Lutz,** who has served as part-time director since June 1952. Mr. Miller was formerly business manager of Southern Baptist Hospital, New Orleans.

Joseph A. Lilli has accepted a position as hospital consultant in the Hospital Survey and Construction Division

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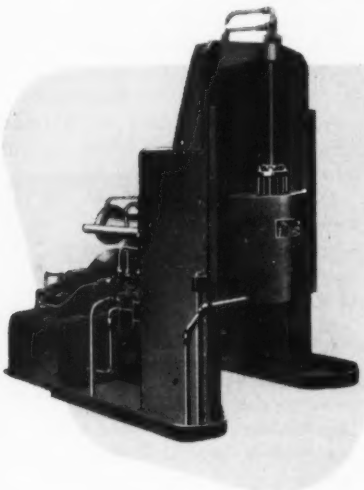
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of the Texas State Department of Health, succeeding **R. B. Fulcher,** who resigned to become administrator-consultant of D. M. Cogdell Memorial Hospital now under construction at Snyder, Tex. Mr. Lilli is the former administrative assistant at Citizens General Hospital, New Kensington, Pa.

Henry W. Aloway, former medical technician for Oxford Hospital, Oxford, Miss., has been appointed administrator of Pontotoc Community Hospital, Pontotoc, Miss., opening in the near future.

Winston Whitfield, administrator of Corinth Hospital, Corinth, Miss., has been named administrator of King's Daughters' Hospital, Yazoo City, Miss. **James McCord,** formerly administrator at the Yazoo City Hospital, resigned his position last March to become a hospital consultant for the Mississippi Commission on Hospital Care. Mr. McCord succeeds **R. L. Purser,** who joined the staff of Washington County General Hospital, Greenville, Miss.

Department Heads

Edith D. Payne has resigned as director of nurses at Presbyterian Hospital, Pittsburgh. As yet, no successor has been chosen.

Evelyn Belknap has been appointed director of the school of nursing and nursing service at Lutheran Hospital, Vicksburg, Miss. She is a graduate of the Mississippi Baptist Hospital School of Nursing, took a postgraduate course at New York Hospital, and holds a B.S. degree in nursing education from Incarnate Word College, San Antonio, Tex. Miss Belknap also has done graduate work at the University of Texas.

Miscellaneous

Col. Charles H. Moseley, MC USA, has been named chief of the preventive medicine division of Army Medical Service Graduate School, part of the Walter Reed Army Medical Center at Washington, D.C. He was formerly chief, environmental control branch, preventive medicine division, Office of Army Surgeon General at Washington, D.C.

Dr. Odin W. Anderson has been appointed director of research for the Health Information Foundation. He will direct a program, including studies on methods of payment for medical care, community self-surveys of health facilities and services, medical public relations, and child health. Dr. Anderson has taught socio-economic aspects of medicine at the University of Western Ontario, London, Ont., since 1949.

Trustees

James F. Stiles Jr., chairman of the board of Abbott Laboratories, has been elected president of the board of trustees of Wesley Memorial Hospital, Chicago, recently, succeeding **Jay L. Hench** who served five consecutive one-year terms.


Dr. Henry W. Cave

Dr. Henry Wisdom Cave has been elected to the board of trustees of Roosevelt Hospital, New York City. Dr. Cave is a consultant surgeon to the hospital and has been affiliated with it in the field of general surgery, serving on the medical board since 1926.

Deaths

Dr. Edward H. L. Corwin died in April after an illness of six weeks. He had been serving as managing director, secretary and treasurer of the Blood Transfusion Association and as special consultant to the committee on public

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health of the New York County Medical Society.

Dr. Corwin was responsible for the development of an information bureau on convalescent care in accordance with standards of the New York Academy of Medicine.

He established an Association of Outpatient Clinics, thus improving medical standards of dispensary work in New York, and was in charge of the first comprehensive survey made of local hospital facilities in the early Twenties. In the years following he made many surveys of individual hospitals and of hospital services in various communities.

Among other activities in the Twenties, Dr. Corwin and his Academy committee studied hospital costs and the capacity of the public to pay for care. He directed a course in institutional management at New York University which gave special attention to hospital management.

Dr. Corwin was also an organizer and had served as secretary-treasurer of the International Hospital Association and had edited its journal.

He was associate professor of public health practice at Columbia University, from which he received the degree of doctor of philosophy in the economic, social and biological sciences in 1910.

Sister Regina Cecila, administrator of Good Samaritan Hospital at Suffern, N.Y., from 1930 until 1948, died last month.



THE BOOK SHELF

THE HEAD NURSE LOOKS AT HER JOB. *A Manual Prepared by the Nursing Division of the U.S. Public Health Service, Washington, D.C.* 1952. $0.40.

Various groups of people have at last recognized the great importance of thoroughly analyzing the head nurse's job. Foremost among these groups is the Division of Nursing Resources, U.S. Public Health Service. This study was made by Ruth I. Gillan, Helen G. Tibbitts and Dorothy Sutherland under the general guidance of Margaret G. Arnstein, chief of the Division of Nursing Resources.

The real reason for such a study is well expressed by Howard A. Rusk, M.D., who wrote the foreword. Dr. Rusk says, "There is an urgent need for self-evaluation studies to find out how effectively hospitals are utilizing professional nursing personnel and to determine whether or not administrative changes might save personnel time and hospital dollars. This manual describes a successful method for studying head nurse activities in hospitals of all sizes and types."

Chapter 1 is devoted entirely to an analysis of the scope and method of the Public Health Service head nurse study. Such things as definitions of personnel to be studied, definitions of activity areas, and definitions of various levels of activity are thoroughly explained.

Chapter 2 explains the actual procedures to be carried out in such a study. This chapter emphasizes the importance of orienting all employes on the nursing unit to be studied so that they will be prepared to cooperate and to understand just what is going on. This chapter also covers the training program for observers.

Chapter 3, covering instructions for observers, is an excellent training manual for the people who are to do the observing and reporting of facts. A typical example in this chapter of excellent instruction is the following: "For example, a head nurse may

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straighten a patient's bedside table simply to create order, or she may do this to obtain a natural occasion to observe the patient's condition. In the first case, the activity is in the 'housekeeping and maintenance' area, at the level of housekeeping personnel. In the second case, the area of activity is 'Patient: other direct activities,' and the level is head nurse."

Chapter 4 contains detailed instructions for preparing tables and data from the observation and facts collected during the actual study. The appendix contains working examples of the recording tables and situations studied.

The nurses in the Public Health Service responsible for the study and the resulting manual are to be congratulated on a splendid addition to hospital nursing literature.—EVERETT W. JONES.

THE ADMINISTRATIVE MANUAL OF ST. MARY'S HOSPITAL, ROCHESTER, N.Y.

At first glance the size and complexity of this manual might tend to discourage people from reading it. However, its authors are to be congratulated on its completeness and clarity of purpose. The following statement by Msgr. John J. Flanagan, S.J., executive director of the Catholic Hospital Association, is significant: "As a tool for the achievement of a better knowledge of operating requirements, the 'Administrative Manual' of St. Mary's Hospital serves most effectively as a vehicle for all levels of staff members; it serves to bring about integration of interests establishing the basis for harmonious interdepartmental relationships. Its educational value for improving administration and more efficient care of the patient cannot be overemphasized."

MIGHT NOT AGREE

There are several points in the manual with which many students of modern administration might not agree. As an example of this, the formal organization chart seems to show entirely too many people reporting directly to the administrator. In a hospital the size of this (335 beds—53 bassinets) it would seem that there should be at least two capable assistants to whom many of the department heads would report. Sound methods of administration in this day and age demand far fewer department heads reporting directly to the administrator. This same problem presents itself in the mail flow chart on page 23. The amount of detail handled by the administrator in connection with the mail is really a waste of the administrator's time.

In connection with the data on the medical staff and the responsibility of the administrator to the medical staff, nothing is said in the manual directly about the use of a medical audit and the important work of the pathologist and an active tissue committee in controlling unnecessary surgery. It seems that this is a serious omission in this otherwise excellent manual.

There can be no question of the tremendous value to any hospital of going through the mental exercise involved in preparing such a manual. The very act of putting down on paper the procedures involved should, in almost every instance, uncover wasteful and unnecessary procedures which can be eliminated or revised.

It would certainly be worth while for every hospital administrator to read this manual and to prepare one along similar lines for his hospital.—EVERETT W. JONES.





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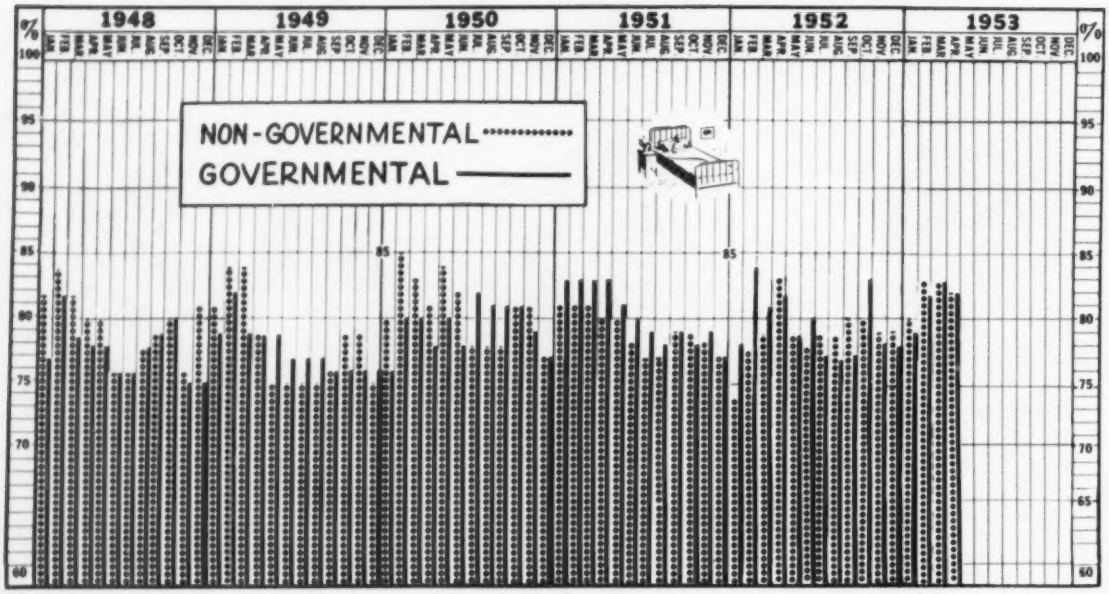
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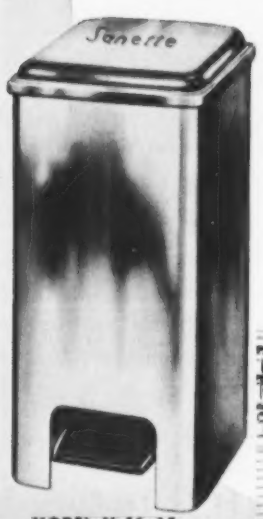
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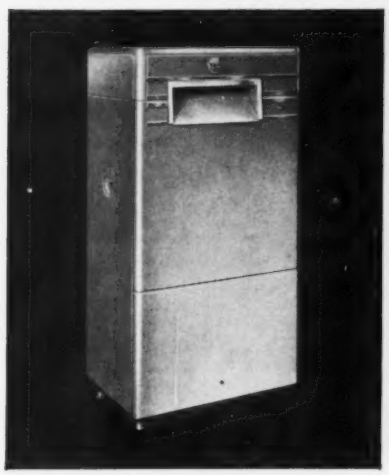


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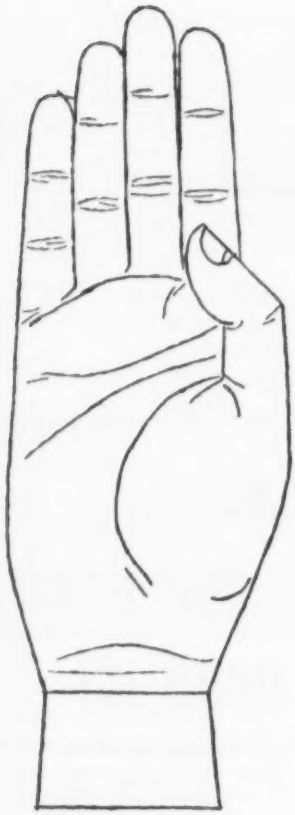
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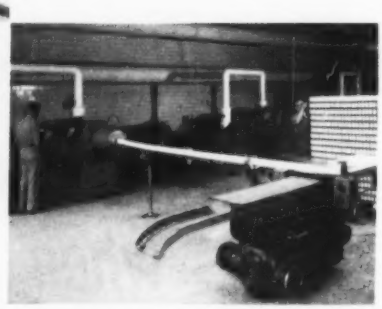
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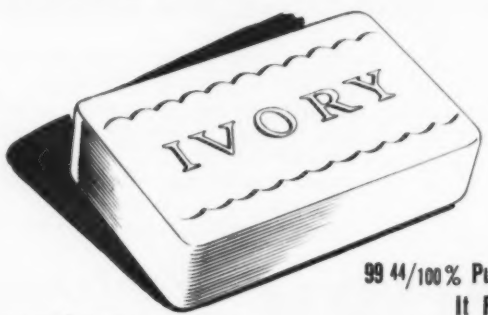
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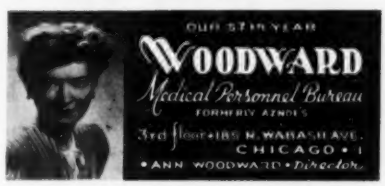
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(Continued on page 204)

WOODWARD—*Continued*

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(Continued on page 206)



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INSTRUCTOR—Assistant, science; registered nurse; immediate opening; school of nursing, 100 students; degree preferred; no training school office relief; living in optional. Apply, Personnel Office, Englewood Hospital, Englewood, New Jersey.

INSTRUCTORS — Clinical; for formal and clinical teaching; 465-bed hospital, 250 students; faculty being increased; teaching load light; salary $3624 to $4224; thirty-one days vacation; hospital has retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital in beautiful 40-acre park. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

(Continued on page 208)



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"DIAMOND-ARROW" CASTERS



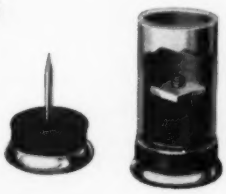
"Diamond-Arrow" Casters, with patented full-floating ball bearing swivel, roll quietly on soft rubber tread, self-lubricating bearing wheels to cushion shocks, protect floors. Electrically conductive wheels are available where required. Furnished with stems and adapters for every type of equipment.

The caster illustrated is equipped with the Bassick rubber expanding adapter. Excellent for easy replacement and tight holding in bed legs.

See the Bassick catalog insert in the Hospital Purchasing File.

RUBBER-CUSHION GLIDES

Rubber-Cushion Glides with flat hardened steel base for chairs and light furniture prevent noisy scraping of floors. May be attached to wood by nail or to metal by machine screw, spring, or expanding rubber adapter.



SERIES "99" TRUCK CASTERS



Series "99" Truck Casters are quiet, easy swiveling, easy rolling, top quality plate casters—ideal for institutional trucks. Sizes 3 in. to 8 in. For light and heavy loads.

THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada:* Belleville, Ont.



Bassick
A DIVISION OF
STEWART SW WARNER
MAKING MORE KINDS OF CASTERS... MAKING CASTERS DO MORE

HERRICK
STAINLESS STEEL REFRIGERATORS
Performance-Proved
at the world-famous
HOTEL CONRAD HILTON
in Chicago



At left is an exterior view of Chicago's magnificent Hotel Conrad Hilton. Occupying half a city block on Michigan Ave., it overlooks Grant Park and affords a beautiful view of the lake. It's America's favorite meeting place.

At right is a HERRICK Freezer Refrigerator used for preserving parfaits and frozen desserts. HERRICK Stainless Steel Refrigerators also serve the Hotel Conrad Hilton's coffee shops and cocktail lounges.





At left is a HERRICK 20-Door Refrigerator serving the Hilton's Banquet Kitchen. It keeps foods at peak freshness and flavor. HERRICK units were supplied by Duparquet, Inc., 225-235 N. Racine Ave., Chicago, Ill.

Largest of all in size and second to none in service, the Hotel Conrad Hilton offers visitors to Chicago the ultimate in gracious living. Its many dining rooms, coffee shops and cocktail lounges are justly famous for their fine foods and beverages. ● Helping to enhance the Hilton's reputation in this respect are a number of HERRICK Stainless Steel Refrigerators, two of which are shown above. Wherever complete food and beverage conditioning is called for, HERRICK Stainless Steel Refrigerators will do a perfect job! HERRICK is unequaled for performance, convenience and low-cost-per-year service. Write today for name of your HERRICK supplier.

HERRICK REFRIGERATOR CO., WATERLOO, IOWA
DEPT. M. COMMERCIAL REFRIGERATION DIVISION

HERRICK *The Aristocrat of Refrigerators*

classified advertising

POSITIONS OPEN

INSTRUCTORS—Nursing arts and Clinical—medical and surgical nursing; immediate openings; fully approved 245-bed general hospital; student body 110, one class annually; accredited school of nursing offering a 3-year diploma program; college affiliation; good personnel policies including 40-hour week; salary open; degree required. Apply, Director of Nursing, Sacred Heart Hospital, Yankton, South Dakota.

MISCELLANEOUS—Available now; excellent opportunities at fully approved 200-bed general hospital with nationally accredited school of nursing; near campus of Rensselaer Polytechnic Institute; affiliated with Russell Sage College; these are permanent positions with a good future and income: Assistant director in education, Nursing arts instructor, Nurse anesthetist, Operating room supervisor, Dietitian (A.D.A.); 40-hour week, paid vacations, holidays, sick benefits, and retirement plan; New York state registration or eligibility. Write immediately to Director of Personnel, Samaritan Hospital, Troy, New York.

MISCELLANEOUS—Clinical instructors, medical and surgical; Science instructor; Operating room suture nurses. Apply, Superintendent of Nurses, Royal Alexandra Hospital, Edmonton, Alberta, Canada.

MISCELLANEOUS — Assistant director of nurses and clinical coordinator; Nursing arts instructor; 300-bed, non-profit hospital, located in beautiful seaport southern city, 20 minutes to the beach, population 50,000; attractive salary and full maintenance; straight 8-hour day, 44-hour week; liberal vacation and sick leave. For information, write Director of Nurses, James Walker Memorial Hospital, Wilmington, North Carolina.

MISCELLANEOUS—Pediatric supervisor and Pediatric nurse; for 125-bed hospital, new addition in process; 44-hour week; salary open. Apply, Director of Nursing, Anniston Memorial Hospital, Anniston, Alabama.

NURSE—Head; in hospital for children with rheumatic fever; excellent salary, good working conditions, maintenance, vacation; near New York City. Apply, Medical Director, Irvington House, Irvington, New York.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSES—General duty; all shifts; 40-hour week; 90-bed general hospital; excellent working conditions; liberal vacations and employee policies; starting salary $264 per month with regular increases; liberal differential for 3-11 and 11-7 shifts; maintenance at nominal charge if desired. Apply, Director of Nursing, East Side General Hospital, 2199 Cadillac Boulevard, Detroit 14, Michigan.

NURSES—General duty, operating and obstetric; modern 55-bed hospital in Pacific northwest; beginning salary $255 per month for 40-hour week; sick leave, holidays, 2 weeks vacation with pay; annual increases; social security and Blue Cross hospitalization plan provided. Apply, Administrator, Memorial Hospital, Sedro Woolley, Washington.

NURSES—General duty and surgical; yearly increments; accumulative sick leave, annual vacation, plus twelve legal holidays a year; salary plus maintenance; one hour from midtown New York. Apply, Director of Nurses, Valley View Sanatorium, Paterson, New Jersey.

NURSES—Graduate, for general staff; General Hospital, Parry Sound, Ontario, Canada (in the heart of tourist district); salary: $145 for days; evenings $155, and nights $150 per month plus full maintenance in nurses' residence; 48-hour week; 2 weeks' vacation plus 8 statutory holidays; increment for first 2 years; also CHARGE NURSE for obstetrical unit. Apply, Director of Nurses.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

(Continued on page 210)

three humidifier regulator units to choose from—ask your supplier for full details



Model No. 714-H

Model No. 764-H

Model No. 754-H

HERE ARE SIX REASONS WHY THE NEW NATIONAL "JET" TYPE HUMIDIFIER UNITS ARE "TOPS" . . . . . .

1. **FOR THE FIRST TIME** you can secure adequate humidification — only the "jet" type nebulizer can accomplish this.
2. For the first time **A MUSICAL NOTE CALLS** the nurse when a kinked tubing interrupts the administration of the needed oxygen.
3. **NO MORE BROKEN GLASS JARS** result from excess pressure or from a sticking rubber gasket.
4. **NO MORE DANGER OF HOSE "POPPING" OFF** and *resulting in permanent interruption of oxygen administration.* Even the slightest stoppage of flow will sound the warning note if it is a National "jet" type unit.
5. **STANDARD MASON TYPE JAR** in large or small size can be used and procured inexpensively from nearby grocery store—if need be.
6. **THE LAST DROP OF WATER** can be utilized because of the long tubing with suction ball resting on bottom of glass jar. This means longer, uninterrupted administration of oxygen.

sixteen revealing pages tell you the full story — it's free — but don't miss it — write today

D

MEDICAL EQUIPMENT DIVISION of NATIONAL Welding Equipment Co., San Francisco 5

National



Why this coil makes *Beautyrest* a firmer mattress!

The secret of firm support in a Beautyrest* hospital mattress comes from the much greater number of independently pocketed coils used — nearly three times the number used in the ordinary innerspring mattress. And Beautyrest mattress coils act *independently* because they are not wired together! Result — firmness over the entire mattress surface. Firmness that yields only to varying body weight.

This greater number of independently acting coils also lets Beautyrest conform to the many positions of posture springs without coils buckling or meshing when the mattress is bent.

Another Beautyrest exclusive — ★★★Three-Star Crushproof Border with coils sewn directly to the border which has been reinforced with a heavily upholstered sidewall and inner roll edge. No side pull — edges last as long as the mattress.

Consider your budget. By comparison, Beautyrest, the mattress built expressly for hospitals, will be your choice. See your hospital dealer, or write Simmons Company.

*TRADE MARK REG. U. S. PAT. OFF.

●

BEAUTYREST FOR HOSPITALS MADE ONLY BY SIMMONS



HAND TEST



Press down on an ordinary mattress. Although it seems firm, it's because the big, wired-together coils pull laterally on each other, pulling the whole mattress into a hollow.

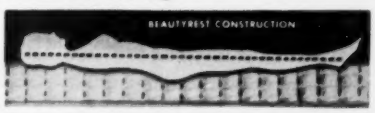


Now try the same test on a Beautyrest. Only one small, independently pocketed coil (the one you press) yields — the others remain upright to retain a firm mattress.

BODY TEST



The same results occur when the patient lies on the ordinary mattress. Notice how the big wired-together coils pull each other down to cause "hammock sag."



Not so with Beautyrest! The far greater number of small coils act independently to give firm, level support that conforms to body contour.

SIMMONS COMPANY
HOSPITAL DIVISION

Chicago 54, Merchandise Mart — New York 16, One Park Ave.
San Francisco 11, 295 Bay St. — Atlanta 1, 353 Jones Ave., N.W.
Dallas 9, 8600 Harry Hines Blvd.

classified advertising

POSITIONS OPEN

NURSES—Operating room and general duty; 42-bed new, well-equipped hospital; 40-hour week; top salary. Apply, Administrator, Tracy Hospital, Tracy, California.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Registered, for supervisory positions and staff nursing for a new and beautifully equipped 100-bed hospital in the Pacific Northwest; excellent salaries and 40-hour week. MO 12, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Registered; for general duty in 70-bed general hospital in San Gabriel Valley, 40 minutes from Los Angeles; close to beaches and mountains; 40-hour week, 2 weeks paid vacation; 6 months increase in salary; paid hospital insurance; starting salary: $235 month; $10 differential for afternoons and nights; $10 differential for surgery and maternity. Write for application form: Superintendent of Nurses, Inter-Community Hospital, Covina, California.

NURSES—Registered; Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Registered; one for Matron of small hospital in nice country village; mostly maternity, and elderly chronic cases; no special training required; also Registered or Graduate nurse. North Queens Cottage Hospital, Inc., Caledonia, Queens County, Nova Scotia, Canada.

NURSES—Registered and Graduate: General duty and Surgery; 40-hour week; $250 base pay, or $15 above present tenure of service monthly salary; one meal per day; vacation, tenure of service raises, evening and night duty premiums and other personnel benefits. Write or phone collect, Administrator, Pioneer Memorial Hospital, Heppner, Oregon.

NURSES—Registered; to work with all-graduate staff in 325-bed industrial hospital; medical and surgical services only; 40-hour week; time and one-half for overtime; increases at six months, one year, eighteen months and two years; beginning salary $10.50 per day for day duty; $11.46 per day for P.M. duty; $11.25 per day for night duty; one meal and laundry of uniforms allowed; full maintenance available at reasonable rates. Apply, Director of Nurses, Missouri Pacific Hospital, 1755 South Grand Boulevard, St. Louis 4, Missouri.

NURSES—Registered; positions available on part-time or permanent basis; salary ranges from $235 to $300 per month or $13 to $15.50 per day, depending on experience. Apply, Director of Nursing, Memorial Hospital, 444 East 68th Street, New York 21, New York. Telephone TR 9-3000, Extension 477.

NURSES—General staff, primarily interested in maternity or gynecologic nursing; opportunity for stimulating experience in a university hospital; cultural and recreational facilities of the university available to the nursing staff; 40-hour week; three-week vacation; beginning salary $265 per month with $1 per day differential for evening or night duty; permanent evening or night duty $30 per month differential; opportunity for advancement; excellent physical plant, beautifully equipped; attractively furnished housekeeping apartments available at $30 per month shared. Apply, Director of Nurses, University of Chicago, Lying-in Hospital, 5841 Maryland Avenue, Chicago 37, Illinois.

NURSES—The Institute of Living offers appointments to the staff of one of the most active psychiatric clinics in the country; practice and study in psychiatric nursing for graduate nurses; residence provided on campus within walking distance of downtown Hartford. Direct inquiries to: Director of Nursing, 200 Retreat Avenue, Hartford, Connecticut.

(Continued on page 212)

Neither the Tulip bulb,
nor the good earth,
nor the gentle rain
can do it alone.



IT TAKES ALL THREE...

And so it is with autoclave sterilization. To be *sure*, it takes TIME, TEMPERATURE and STEAM!

ONE GLANCE REDUCES CHANCE

Just a glance at the A-T-I STEAM-CLOX indicator provides graphic aid in checking *all three elements* essential to sterilization *inside every single* pack. A-T-I STEAM-CLOX offers this 3-*way* type of warning!



GENEROUS COMPLIMENTARY SAMPLES
and complete Sterilization File

manufactured by **ASEPTIC THERMO INDICATOR CO.**
5000 W. Jefferson Blvd., Dept. MH 26
Los Angeles 16, Calif.

AT LAST!
Dexter Diapers
The diaper that does away with half the work in your laundry and nursery.

BECAUSE
Dexter Diapers eliminate all folding in your laundry and nursery.

SPECIAL LOW PRICE TO HOSPITALS
Write direct to manufacturer or ask your favorite diaper service.

Most popular diaper used today in hospitals over the nation . . . from local diaper services or in their own laundry.

DEXTER DIAPERS
Ask Your Favorite Diaper Service, Department Store or Baby Shop.

SEND 25c TO
FRED DEXTER, MFR.
Dept. M. H. Houston 8, Texas
FOR 1. Sample Diaper 2. Pins-on-Chains 3. Helpful Booklet
ALL 3 FOR ONLY 25c
IDEAL BABY SHOWER GIFT
We Lose Money On This Offer



New! mechanical bed lift

SAVES BACK STRAINS



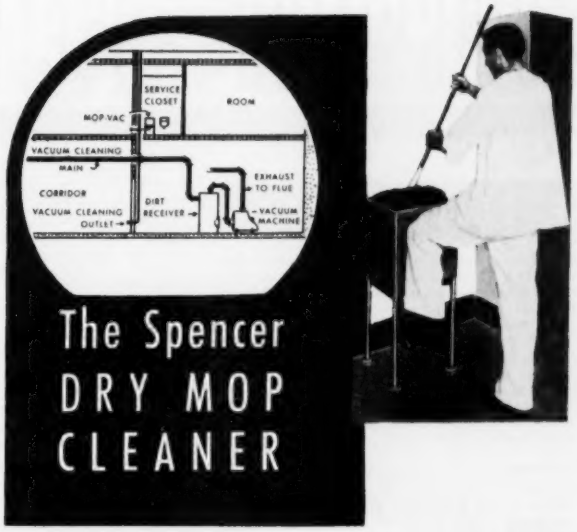
No more heavy lifting when the head or foot of a bed needs to be raised. No more hydraulic oil leaks.

The De Puy Mechanical Bed Lift gears and turning arm, allow a 100 pound nurse to raise a heavy patient and hospital bed. Swivel rollers let you easily roll this bed lift wherever needed. Bed lift can be left in place, or replaced with blocks and used to raise another bed.

Write for complete information and FRACTURE CATALOG



De Puy
MANUFACTURING CO., INC.
Warsaw, Indiana



The Spencer DRY MOP CLEANER

Hospitals equipped with Spencer Vacuum Cleaning will never have a dry mop cleaning problem. A Spencer Mop-Vac cabinet is located in a service closet on every floor. No extra steps—and all the dust goes down the vacuum system to the basement.

The Mop-Vac consists of a slotted plate mounted flush in the floor or on a box cabinet with a foot operated valve. Open the valve and air rushes through the slot. Pass the mop over the slot and the high velocity air agitates the strands, and removes the dust. Dust cloths are cleaned the same way.

Standard Spencer Vacuum Tools connected to the Stationary System may also be used for general cleaning of floors, walls, furniture, mattresses or hard-to-reach places, such as air conditioning ducts and grills.

SIX DIFFERENT TYPES



Cabinet units are made in three types: The open type illustrated above, and high and low enclosed cabinet types.

The simple attachment illustrated at the right may be inserted in the Spencer baseboard inlet valve. The Spencer floor valve may be connected to the pipe system under the floor, and a box type is available for attaching to the Spencer Portable Vacuum Cleaner. Ask for Bulletin No. 138-C on Spencer Mop-Vac and Bulletin No. 133 on Stationary Vacuum Cleaning Systems.

THE SPENCER TURBINE COMPANY • HARTFORD 6, CONNECTICUT

SPENCER
HARTFORD

450-A

classified advertising

POSITIONS OPEN

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff and Operating room; 5 days, 40 hours 8 holidays and vacation with pay; initial salary $230 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

RESIDENTS—Two, with Michigan license, for 110-bed approved general hospital; living quarters available; liberal salary. MO 38, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SALES EXECUTIVE—Leading National manufacturer of metal hospital furniture requires an experienced man to head its national sales organization for the hospital field; unusual sales executive opportunity with well established, nationally recognized manufacturer; headquarters in Chicago; applicant must have thorough knowledge of and experience in hospital field; please state in first letter full details of experience, age, education, family, income requirements; all replies fully confidential. Reply, MO 39, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—And Clinical instructor for pediatrics; experience and advanced preparation necessary, preferably a degree; for modern 250-bed hospital, fully approved, 70 miles from New York City; 40-hour week; 3 weeks paid vacation; sick time; hospital care; complete maintenance, if desired, at $45 per month; beginning salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISOR—Obstetric, afternoon duty; obstetric and gynecology hospital in nation's capital; salary open. Reply, Adda Johnson, R.N., Directress of Nurses, Columbia Hospital for Women, Washington 7, D. C.

SUPERVISOR—Obstetric; Bachelor's Degree, with experience preferred; may consider postgraduate course and experience; duties: administrative, teaching, reorganizing department, teaching students formal classes, clinical teaching; personnel policies: 44-hour week, social security, insurance. The Ohio Valley Hospital, Steubenville, Ohio.

SUPERVISOR—Operating room; 300-bed general hospital, new modern operating room suite; adequate staff, student body; 40-hour week, 28 days vacation, good personnel policies; mature, experienced person desired; salary open. Apply, Director of Nursing, Fitkin Memorial Hospital, Asbury Park, New Jersey.

SUPERVISOR—Registered nurse; 30-bed nursing home; practical nurses employed; $230 per month, maintenance; near Washington, D.C. Kensington Gardens Nursing Home, 3000 McComas Avenue, Kensington, Maryland.

SUPERVISORS—Assistant director of nursing; for 400-bed hospital with school of 200 students; full information on application; also, Night supervisors, two (four night supervisors on 44-hour week rotation shifts); gross salary minimum: $250; 1 month vacation and 21 days sick leave per year. For further information, apply Director of Nursing, City Hospital, Saskatoon, Saskatchewan, Canada.

TECHNICIAN—Chief; teaching and supervisory ability required; 250-bed hospital; approved training program; salary open. Apply, Pathologist, Ohio Valley Hospital, Steubenville, Ohio.

TECHNICIANS—For general laboratory work; in 338-bed hospital; salary dependent on qualifications. Apply: Pathologist, York Hospital, York, Pennsylvania.

TECHNOLOGIST—Laboratory; registered, to work in 70-bed hospital in south Kentucky city; starting salary $300 plus uniform laundry, plus six legal holidays with pay, plus two weeks vacation after one year's service; excellent working conditions. Write, W. S. Murphy, Administrator, Somerset City Hospital, Somerset, Kentucky.

(Continued on page 214)

maggi works magic with flavor!



MAGGI'S SEASONING

Sleight-of-hand with a dash of Maggi's Seasoning develops food flavor to its peak and keeps it there. Old-world chefs have used this trick for years . . . making the subtle hidden flavors of soups, stews, gravies, vegetables and meat spring to life.

IN HANDY QUART SIZE WITH "STEADY FLOW" POURING SPOUT

MAGGI'S GRANULATED BOUILLON CUBES

Cooking magic with Maggi's Granulated Bouillon delights the most discriminating patron. Enrich gravies, sauces, vegetables and stews with economical-to-use Maggi's . . . which also makes an excellent full-flavored stock or an instant beverage.

PRODUCTS OF THE NESTLÉ COMPANY, INC.
WHITE PLAINS • NEW YORK

maggi's
world-famous flavor products

seasoning... granulated bouillon cubes

NUMBER 5 OF A SERIES

CURRY SAUCE...for fowl or meat!



2 oz. butter • 2 oz. flour • 2 tsp. curry • 1 onion chopped • ½ clove garlic • ½ apple grated • 1 tbsp. and 1 tsp. MAGGI'S GRANULATED BOUILLON dissolved in 1 pt. 6 oz. boiling water • ¼ c. moist cocoanut.

Saute onion and garlic in butter for 5 min. Mix flour and curry, add to butter mixture. Gradually add broth stirring until smooth. Lastly add moist cocoanut, 1 pint.



Poor acoustics and noise interference destroy efficiency and tax the strongest nerves.

FIR-TEX Perforated Acoustical Tile controls sound easily, economically. It is a finer material for sound control in hospital operating rooms, wards, corridors and offices. It is engineered for quick, low-cost installation and maintenance. Fir-Tex Perforated Acoustical Tile traps noise like a blotter soaks up ink.

FIR-TEX is made of strong, tough wood fibers, felted together and pressed into a rigid tile in such a way as to preserve the natural air cells within the fibers and add millions more sound-absorbing cells between fibers. Exposed surface is then perforated for even greater sound absorption. Also available with special flame-resistant surface at slight additional cost.

Learn more about the advantages of FIR-TEX Perforated Acoustical Tile from your architect.



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STOP



Wasting Time Scrapping & Pre-Washing By Outdated Methods

A Salvajor Scrapping & Pre-Wash Machine does it all in one operation—with one motion. Completely eliminates hand scrapping of dishes and does a faster better pre-washing job than any other method. In addition, Salvajor TRAPS LOOSE TABLEWARE—preventing loss in the food scraps. And it collects and washes food waste, reducing volume as much as 50%.

LOOK



At The Newest Low Cost Food Waste Disposer

The New Model "L" WASTEXIT is the first and only ½ H.P. commercial food waste disposer in the LOW PRICED field! It has the power and ruggedness needed for continuous operation—and it disposes all kinds of food scraps, including difficult preparation waste. Adaptor Assemblies are available for either scrap table or meat/vegetable preparation table.

Then

LISTEN

To This

The Salvajor and Model "L" WasteXit offer excellent kitchen planning possibilities as they can be installed where they are most needed without taking valuable work space. For large food service operations Salvajor and Model "L" WasteXit multiple installations can meet any scrapping, pre-washing and disposal need.

For Complete Details—including space and utility requirements, write today.

The SALVAJOR COMPANY

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Kansas City, Missouri

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EQUIPMENT Is Recognized and Proved in the Nation's Leading *Institutions*

Springdale Hospital, Springdale, Ark.
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and others from coast to coast

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POSITIONS OPEN

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical; to direct program, organization with broad goal of improving quality of medical care; diversified activities including graduate program for physicians; university center. (b) Assistant medical director; fairly large hospital; California. (c) Voluntary general hospital, 225 beds; university town, midwest. (d) Small general hospital recently opened for operation, resort town, east. (e) Voluntary general hospital recently completed; fairly large size; Pacific coast. (f) Small general hospital completed '51; expansion program; Pacific Northwest. (g) Community hospital, 75 beds; college town, south. (h) Assistant; minimum four years' experience, accounting background; 225-bed hospital; resort town, midwest; $8000. (i) Assistant; voluntary general hospital, 250 beds; graduate in hospital administration required; college town, east. (j) Assistant; accounting background; general hospital, 300 beds; university town, west. MH6-1.

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) General hospital, 75 beds; residential town near university center; midwest. (b) New hospital, 65 beds; resort town, east. (c) Chief nurse; general hospital, 125 beds; South America; knowledge of Spanish advantageous; staff of American physicians. MH6-2

ANESTHETISTS—(a) 300-bed general hospital; university city, west; $500. (b) Small general hospital; resort town located on island; $450, maintenance. (c) Association, group of anesthesiologists; resort city, southwest. MH6-3

DIETITIANS—(a) Administrative; 300-bed general hospital; teaching affiliations, college town adjacent large medical center; east; minimum $5500. (b) Chief; new hospital, 400 beds, affiliated university medical school; west. (c) Chief and therapeutic dietitians; teaching hospital, 500 beds; new department, university center; midwest. (d) Two therapeutic dietitians; new hospital, 600 beds; university center; south. (e) Director of food service and instructor in home economics; university appointment; midwest. MH6-4

DIRECTORS OF NURSES—(a) Research and teaching hospital maintaining highest standards of medical and nursing care; 250 students; university medical center, midwest; outstanding opportunity. (b) Voluntary general hospital; 240 beds, expansion program; highly regarded school; California; $7200. (c) New hospital, 400 beds, affiliated university medical school; west. (d) Voluntary general hospital, 500 beds; teaching affiliations; 200 students; five-year course; university center, midwest. (e) Nursing service only; large general hospital, Chicago area; $6000. (f) Nursing service; modern hospital, 100 beds; small resort town, east. (g) Nursing service; new hospital currently under construction; 200 beds; $5000, maintenance; east. MH6-5.

EXECUTIVE HOUSEKEEPER—One of the country's leading teaching hospitals; 800 beds. MH6-6.

EXECUTIVE PERSONNEL—(a) Comptroller, qualified as business manager; new hospital; $10-$12,000; midwest. (b) Personnel director; qualified to serve as assistant administrator, 300-bed hospital; east. (c) Purchasing agent; university group; large city medical center, east. MH6-7

FACULTY APPOINTMENTS—(a) Educational director; new program for graduate nurses working toward advanced degrees; Pacific coast. (b) Educational director; small hospital; new institution under construction; small school fine affiliations; North Carolina. (c) Assistant professor, medical and surgical nursing; collegiate school; 4-year basic program, leading to B.S. degree; east. (d) Educational director; children's hospital; interesting city, outside United States. (e) Educational director; recently established collegiate school; $5000-$6000; California. (f) Public health coordinator and clinical instructor; rural com-

(Continued on page 216)

In the Hospital, "SILVER SERVICE" can be PSYCHOLOGICAL!



. . . also Good Hospital Economics!

EDWARD DON & COMPANY

Letting a patient eat in grandeur, feeling like a queen (or king) for the day does something for morale. That's why so many hospitals serve patients with silverplated tea and coffee pots, creamers and sugars, plate covers, butter dishes, etc. They also serve with good silverware, china, glassware, napkins.

It's good business to do so, too. Patients, especially in private rooms, like to feel they are getting extra service in more ways than one. It's good "guest" relations and—you know how patients afterwards talk about their operations—it proves to be good publicity, too.

Silverware and other fine serviceware are only a few of the 50,000 items of Equipment — Furnishings — Supplies sold by DON for hospitals and other institutions. What are your needs now?

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WHY TAKE CHANCES WITH CITRUS FRUIT FLAVORS?

CRAMORES CRYSTALS

assure the same fine quality taste and flavor you'd get in the real fruit itself . . . with none of the changes due to climate and season, none of the time-consuming bother of squeezing.



CRAMORES CRYSTALS are made from a base of pure, dehydrated citrus fruit juices with fruit components added, to bring you top quality goodness all year. Compact and easy to store.

they're Economical, too!

- *No risk of waste or spoilage*
- *Cost about half as much as fresh fruit*
- *Need no refrigeration*

Try CRAMORES CRYSTALS in Cooking . . . Baking . . . Beverage Making of all kinds.

5 DELICIOUS FLAVORS:
LEMON LIME
LEMON & LIME
ORANGE
LEMON WITH EGG WHITE

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Order from your dealer or write:

CRAMORE FRUIT PRODUCTS, INC.
Point Pleasant, N. J.



Now... heat and serve foods in plastic coated paper containers

With this new Sealright food container you can heat and serve all types of prepared foods – *right in the same container!* When it's empty – throw it away. Saves time in rooms and cafeterias . . . reduces costs by eliminating dishwashing and dish breakage.

Sealright's plastic coating holds the true flavor of coffee and all cooked foods – including those with sauces and gravies. It will not wilt or drip. And its sturdy, porcelain-like rim makes drinking easier and pleasanter than with other types of paper containers.

Hospitals everywhere are discovering new time-saving uses for these Sealright Alservis containers. You can, too. Call your local paper supplier, or send coupon – now.

OSWEGO FALLS CORP. — SEALRIGHT CO., INC., FULTON, N. Y., KANSAS CITY, KANSAS • SEALRIGHT PACIFIC, LTD., LOS ANGELES, CALIFORNIA
CANADIAN SEALRIGHT CO., LTD., PETERBOROUGH, ONTARIO, CANADA

Sealright

alservis nestyle

plastic coated paper food containers



Send for FREE samples and facts today

SEALRIGHT CO., INC., FULTON, N. Y.

Send me free samples and complete facts on how plastic coated Alservis Nestyle paper food containers can speed our feeding and cut costs:

*Name*_____ *Title*_____

*Hospital Name*_____

*Address*_____

*City*_____ *Zone*____ *State*_____

MH-4

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

munity collegiate program; east. (g) Nursing arts and medical-clinical instructors; faculty appointments at university level; northwest. MH6-8.

MEDICAL LIBRARIANS—(a) Medical library for Americans; Asia. (b) New library; medical school; west. MH6-9.

RECORD LIBRARIANS—(a) Chief, medical record section; new medical center; competent organizer required; $5000-$6500. (b) Small general hospital; college town, southern California. (c) Male; to take charge of library and medical records section, 600-bed hospital; university center. MH6-10.

STUDENT AND PUBLIC HEALTH, SCHOOL—(a) Director, department, public health services, 300 beds; residential town, near New York. (b) Director, student health, social program; 400-bed hospital; college town, east. (c) School; military academy; midwest. MH 6-11.

SUPERVISORS—(a) Operating room; large teaching hospital; university city; midwest. (b) Pediatric; 500-bed teaching hospital; university center, east. (c) Obstetrical; 200-bed hospital; resort town, California. (d) Emergency room; 300-bed teaching hospital on campus university; midwest. (e) Operating room; large general hospital; teaching affiliations; California. (f) Pediatric and obstetrical; university hospital; Asia. (g) Outpatient, central supply, pediatric, obstetrical; new hospital, residential town, east. (h) Supervisors, various departments; new 400-bed hospital nearing completion; affiliated medical school; west. (i) Operating room; one of leading hospitals, New York City; outstanding opportunity. MH6-12.

STAFF NURSES—(a) Two general duty, one surgical; 200-bed hospital; outside United States; tropical. (b) Hospital, foreign operations, American company; $350, maintenance. (c) Surgical; teaching hospital; $300, up; university center. MH6-13.

BUSINESS AND MEDICAL REGISTRY (Agency)

Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

MEDICAL RECORD LIBRARIANS—(a) Large tuberculosis hospital near Los Angeles; $400. (b) Catholic hospital of 75 beds, northern California; $350.

OPERATING ROOM SUPERVISOR—One of southern California's finest training schools; degree and supervising experience required; excellent salary.

(Continued on page 218)

BUSINESS AND MEDICAL REGISTRY—*Continued*

INSTRUCTOR—Southern California hospital; degree and teaching experience; desirable connection and one of the most picturesque locations on the Californin coast; salary open.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) West; large hospital; must have good experience; excellent opportunity; $15,000 plus automobile and expenses. (b) West; 30-bed industrial hospital; $6000 to start. (c) Assistant; east; 250-bed hospital; excellent opportunity to gain valuable experience working under a highly qualified administrator. (d) Southwest; 60-bed general hospital in process of expansion to 100 or 125 beds; fine opportunity for a young man to show his mettle.

PERSONNEL DIRECTOR—Middle west; 200-bed general hospital in city of 75,000; excellent opportunity for a young man with a good background in personnel work; $6000.

BUSINESS MANAGER—Middle west; 250-bed general hospital; requires good experience as business manager in a hospital of comparable size; $6000 minimum to start.

Only **POUR-O-VAC SEALS**

afford a practical means of avoiding a wasteful, inconvenient, time-consuming and questionably scientific method of sealing and handling your supply of surgical solutions ... and routinely checking the sterility of contents during long storage periods without breaking the hermetic seal.

... and with it goes

1. **Supply Conservation** ... provides dustproof seal for remaining fluid when only partial contents of a container are used.
2. **Supply Conservation** ... eliminates need to utilize gauze, cotton, paper, string or tape to effect makeshift seal of questionable efficiency.
3. **Supply Conservation** ... reduces possibility of breakage or chipping damage to lips of Fenwal containers.
4. **Supply Conservation** ... POUR-O-VAC SEALS* are reusable ... may be sterilized repeatedly ... interchangeable for use with 500, 1000, 1500, 2000, 3000 ml. FENWAL containers.

*A product of Fenwal Laboratories, Inc.

ORDER TODAY or write us for detailed information

MACALASTER BICKNELL PARENTERAL CORP.
243 Broadway Cambridge 39, Massachusetts



Contents pour from a sterile lip

THE SOLUTION DESIRED — THE Fenwal SYSTEM — AT THE INSTANT REQUIRED

ANCHOR BRUSH COMPANY ANNOUNCES

NEW ALL-NYLON EMESIS BASIN



- Light in weight...as indestructible as steel...less expensive.
- Does not chip, peel, crack, dent or break when dropped.
- Can be boiled, autoclaved or washed in a dish-washing machine, without damage.
- Virtually noiseless in handling—a real benefit to all patients.

Supplied in ten inch size

OTHER PRODUCTS OF THE ANCHOR BRUSH COMPANY



All-Nylon Surgeon's Brush

All-Nylon Drinking Tumblers



Free sample of new emesis basin supplied to dealers on request by writing to The Barns Company.

Sold Only Through Selected Hospital Supply Firms

ANCHOR BRUSH COMPANY

AURORA, ILLINOIS

Write for Complete Information to Exclusive Sales Agent

THE BARNS COMPANY

1414-A Merchandise Mart • Chicago 54, Illinois



"Our new Bloomfield truck paid for itself in 3 months!"



Model No. 56 (above)



CUT OVERHEAD COSTS with STAINLESS STEEL ALL-PURPOSE TRUCKS by BLOOMFIELD

All-purpose trucks by Bloomfield are designed to serve efficiently and quietly in every part of today's modern hospital. Ideal as: *a kitchen truck, *surgical instrument cart, *medicine cart, *hospitality cart, *maid's truck *for transporting diathermy equipment, *for virtually every hospital moving job.

Write for information on specially designed trucks to meet other needs.

MODEL NO. 56 LOW-COST TRUCKS

Model No. 56 (photo above) is a low-cost, sturdily made truck that will give years of useful service. Made of mirror-finished Enduro stainless steel, it can be kept perfectly clean with just minimum care. Available with or without stainless steel accessories as shown. Dimensions 27" long (including handle) x 31" high & 15½" deep. Price—$29.95.

MODEL NO. 36 HEAVY-DUTY TRUCK

Model No. 36 is a ruggedly built truck, larger than No. 56 above, and is designed for durability and performance. Easily carries 350 lbs. Made of finest quality, heavy-gauge stainless steel, beautifully mirror-polished for complete cleanliness. Mounted on soft rubber-tired, ball bearing casters. Soundproof. Available with or without accessories. Dimenisons: 30" long (including handle) x 31" high x 16½" deep. Price, $36.95.

ACCESSORIES FOR NO. 36 TRUCK

1. No. 236 Bin—Same as above.
2. No. 136 Bin—Same as above.
3. No. 37 Carrier—Smoothly finished stainless steel, with extra reinforcement, and rolled handles. Larger than No. 57 above. Price—$12.50.

LOW-COST ACCESSORIES FOR NO. 56 TRUCKS

1. No. 236 Bin—For silverware, condiments, medicines, other small items. Easily removable. Price—$6.49.
2. No. 136 Bin—For food scraps, soiled or clean linens. Quickly cleaned. Removable. Price—$12.95.
3. No. 57 Carriers—For carrying foods, candies, bottles, dirty dishes, etc. Leakproof, sanitary. Smooth rolled handles. Price—$10.50.



Model No. 36

Bloomfield All-Purpose trucks can also be supplied in extra heavy gauge galvanized steel for use where stainless steel is unnecessary.

Model No. 34 (same dimensions as No. 36). Price—$22.95. Galvanized steel accessories similarly low priced.

SEE YOUR JOBBER

Please send me complete details on Bloomfield All-Purpose trucks. Also send my copy of the new Bloomfield catalog of more than 200 important hospital items.

NAME .....

POSITION .....

HOSPITAL .....

ADDRESS .....

CITY ..... ZONE ..... STATE .....

BLOOMFIELD INDUSTRIES, Inc.

4546 WEST 47TH STREET

CHICAGO 32, ILLINOIS

NEW YORK • LOS ANGELES

classified advertising

POSITIONS OPEN

SHAY—*Continued*

CLINICAL PSYCHOLOGIST—Will conduct psychological examining of psychiatric patients, psychotherapy and research; also participate in the training of psychology interns; to $5100.

DIETITIANS—(a) Chief; east; 150-bed general hospital, fully approved; all facilities complete and modern; $4800 plus maintenance. (b) Assistant; east; 290-bed hospital, fully approved; assist supervising dietitian in preparing for and serving approximately 220 patients; $3600. (c) Chief; south; new ultramodern 70-bed hospital located in beautiful resort area; climate mild in winter; ideal in spring, summer and fall. (d) Assistant; east; 150-bed county hospital; no nursing school; supervise service of all foods for patients on special diets; $3400 to start.

EXECUTIVE HOUSEKEEPERS—(a) South; new ultramodern 70-bed hospital located in beautiful resort area; climate mild in winter; ideal during other seasons. (b) Middle west; 110-bed general hospital; two buildings of sixty and fifty beds each; excellent staff of competent workers. (c) East; large teaching hospital; complete responsibility for department excepting the manufacture, repair and issuing of linen. (d) Middle west; 325-bed hospital located in large city; approximately 100 employees in department.

SHAY—*Continued*

OCCUPATIONAL THERAPISTS—(a) Supervisor; head department of 600-bed teaching hospital; facilities complete and modern; three employees in department; to $4200. (b) Administrative; 28 employees in department; well known institution for care of neuropsychiatric patients; occupational therapy program is one of most outstanding in the world; to $4500. (c) New, modern hospital with bed capacity of about 300, affiliated with well known university; this is an unusual opportunity.

PHARMACISTS—(a) Assistant; midwest; 250-bed general hospital, fully approved; three in department; to $4500. (b) Northwest; 800-bed general hospital, fully approved; 5 in department; $350-$400. (c) California; 200-bed general hospital; complete charge of department; $5600. (d) Midwest; 325-bed hospital; 4 in department; attractive summer resort location; to $4500.

PURCHASING AGENTS—(a) Midwest; 300-bed general hospital; $5000. (b) Eastern medical center; comprising several hospitals; full charge; $5000 minimum. (c) Assistant; east; medical purchasing experience not required; $3500.

LAUNDRY MANAGERS—(a) East; large hospital within commuting distance of Baltimore; $4200. (b) Midwest; large, approved teaching hospital; thirty employees in department; excellent opportunity for well qualified man.

(Continued on page 220)



OUR 57th YEAR

WOODWARD

Medical Personnel Bureau

FORMERLY AZNOE'S

3rd floor • 185 N. WABASH AVE. CHICAGO • 1

• ANN WOODWARD • *Director*

If None of These Opportunities Meets Your Requirements, Please Ask for an Analysis Form So We May Prepare an Individual Survey for You.

Strictly Confidential

ADMINISTRATORS—(a) Assistant; medical; very important 700-bed teaching hospital; opportunity succeeding present director; metropolis. (b) Lay; general hospital, municipally operated; about 800 beds; central. (c) Lay; new general hospital, 225 beds; around $15,000; one of most modern on west coast. (d) Lay; voluntary general hospital; 300 beds; around $18,000; excellent city; midwest. (e) Medical; assistant; general hospital; 800 beds; very desirable coastal city; California. (f) Lay; voluntary general hospital; 150 beds; lovely college town 100,000; midwest. (g) Medical; assistant; industrial hospital, small size; Hawaii.

FOR BRIGHTER FLOORS

SAVES MONEY

Brillo solid-disc steel wool floor pads work evenly . . . apply wax or seal smoothly, without streaks or swirls. Daily once-over removes traffic grime—makes original waxing last longer. Gives brilliant finish to linoleum, asphalt or rubber tile, wood, and terrazzo. Sizes for all machines.



For free folder on low-cost Brillo floor care, write to Brillo Mfg. Co., Dept. M, 60 John St., Brooklyn 1, N. Y.

BRILLO Floor Pads make waxings last longer

CLEANS BETTER

Greater polishing action with solid disc



BRILLO

SOLID-DISC STEEL WOOL

FLOOR PADS

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For a quarter century our campaigns have succeeded not only financially, but in the excellent public relations we have established for our clients.

Consultation without obligation or expense.

CHARLES A. HANEY & ASSOCIATES

INCORPORATED

259 Walnut St. • Newtonville, Mass.

New PHILCO Thermo-Cool Room Air Conditioner

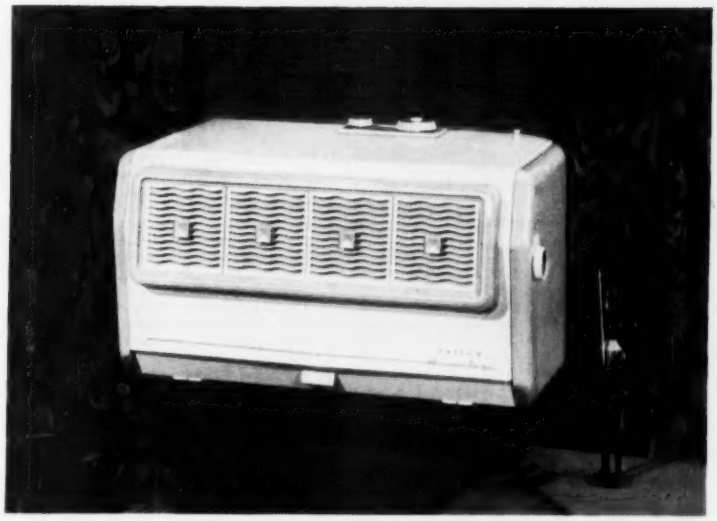
. . . Cools or Heats !

Heats the **same size** room it cools . . .

Heats **as fast** as it cools!

Philco leadership brings it to you now . . . a sensational Reverse Cycle Room Air Conditioner that cools the air on hot days and heats the air on chilly days. Truly double-duty, in many sections of the country it's the answer to year 'round comfort, and everywhere it greatly lengthens the season for maximum use of a Room Air Conditioner. For full details of this as well as other Philco advances, mail the coupon below. There's a new Philco for any size room.

Every Philco carries a 5-YEAR WARRANTY

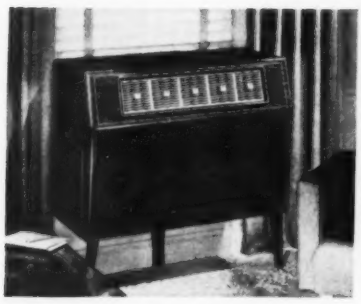


The secret is a new Thermo-Cool

REVERSE CYCLE UNIT

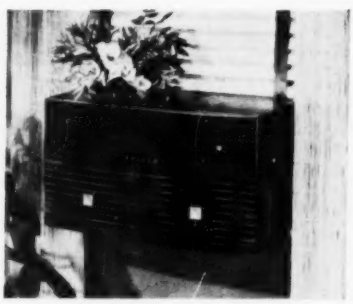
. . . not mere heating coils of limited wattage

Philco's Reverse Cycle system is available on ¾ H.P. air conditioners like the Philco 86-JL, shown above, and also on 1 H.P. window models. In addition, they are equipped with Automatic Temperature Control that regulates cooling without shutting the unit off, plus 4-way adjustable grilles for directing the air up, down, to the left or right, or any combination of the four directions.



New *Consolette* Unit Does Not Extend Outside the Window

True air conditioning in space-saving cabinet, specially designed for hard-to-fit rooms and casement windows. Available with 1 H.P. or ¾ H.P. unit.



Special ½ H.P. Window Model at New Low Price

New for 1953—the Philco 50-J. Cools, dehumidifies and filters the air. Get the full story of Philco Air Conditioners, the leader everywhere in cool comfort.

PHILCO

WORLD'S LARGEST SELLING ROOM AIR CONDITIONERS FOR 16 STRAIGHT YEARS

—MAIL COUPON TODAY—

Philco Air Conditioners, Dept. F3
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Gentlemen: Please send me free Air Conditioner booklet with news of exclusive Philco developments.

Name .....

Address .....

.....

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

ADMINISTRATORS—NURSES. (a) Preferably nurse-anesthetist; new general hospital, 40 beds; minimum $5000; Michigan. (b) General hospital 100 beds; new post; town 90,000; New England. (c) New hospital starting construction; around 50 beds; lovely residential town; midwest. (d) Voluntary, general hospital, 50 beds; expansion program; $5000, full maintenance; town 35,000; west mountain state.

ADMINISTRATIVE POSITIONS—(a) Personnel director; teaching hospital, 350 beds; around $5000; large city; university medical center; midwest. (b) Purchasing agent; experienced; general hospital, 250 beds; college town 75,000. (c) Accountant; supervise staff of ten; children's hospital, 200 beds; city 500,000; midwest.

ANESTHETISTS—(a) General hospital, 300 beds; $500; university medical center city; southwest. (b) Voluntary general hospital; $500; male considered; city 50,000; Michigan. (c) Hospital group; $550; 70 beds; lovely small college town; southeast.

DIETITIANS—(a) Chief; complete supervision; 90 employees in department; requires A.D.A.; general voluntary hospital, 300 beds; California. (b) 500-bed general hospital; Michigan. (c) Chief; 250-bed voluntary general hospital; around $450; city 50,000 near Toledo. (d) Chief; full charge; teaching and therapeutics; voluntary general hospital; 100 beds; lovely town; Illinois.

DIRECTORS OF NURSES—(a) Complete charge nursing service and education; requires degree; voluntary general hospital, 150 beds; 25 students; $400, full maintenance including lovely quarters; Maryland. (b) Nursing and education; voluntary general hospital, 500 beds; $6000; east. (c) County home; 500 patients; civil service; substantial salary; large city; west coast. (d) General hospital, small size; $350; full maintenance; Indiana.

FACULTY APPOINTMENTS—(a) Educational director; full charge; voluntary general hospital; 300 beds; minimum B.S.; town 135,000, near two medical schools; $6500; central. (b) Associate educational director; minimum B.S.; chairman, admissions committee; assist planning total curriculum; voluntary general hospital, 150 beds, town 100,000; near Boston. (c) Educational director; modern general hospital, 400 beds; excellent school; 70 students; $6000, full maintenance; university city; east. (d) Instructor, science; preferably qualified in virology; teach medical students; opportunity research; $5000; university school; large city; west. (e) Clinical instructors; two required; general voluntary hospital, 200 beds; approved school; around $350; meals; lovely residential suburb near two medical schools. (f) Nursing arts instructor; collegiate school; NNAS approved; 100 students; position carries full faculty status; city 400,000; Pacific coast.

HOUSEKEEPERS—(a) Executive; one of country's most important university hospitals; 1000 beds; substantial salary; east. (b) New children's hospital, opening July; affiliated university school; large city; south.

RECORD LIBRARIANS—(a) Chief; registered; voluntary general hospital, 100 beds; top salary; ideal working conditions; mideast. (b) Chief; registered; general voluntary hospital, 600 beds; substantial salary; large city; university medical center; east.

SUPERVISORS—(a) Central supply; surgery; voluntary general hospital, 250 beds; city 140,000, one hour from Chicago. (b) Operating room; 300-bed general hospital; town 70,000; New England. (c) Pediatric; department of 30 beds; one of the best in the state; general hospital, 125 beds; town 40,000 one hour to Chicago. (d) Obstetrical-clinical; 150-bed general hospital; town 75,000; southeast. (e) Medical and surgical floor; capable developing in-service program; units of 100 beds; general voluntary hospital, 500 beds; substantial salary; one-half hour to New York City. (f) Surgical nurse; industrial hospital; 45 beds; around $400; west-mountain.

(Continued on page 222)

YARDSTICK OF QUALITY

...more than 20 years long!





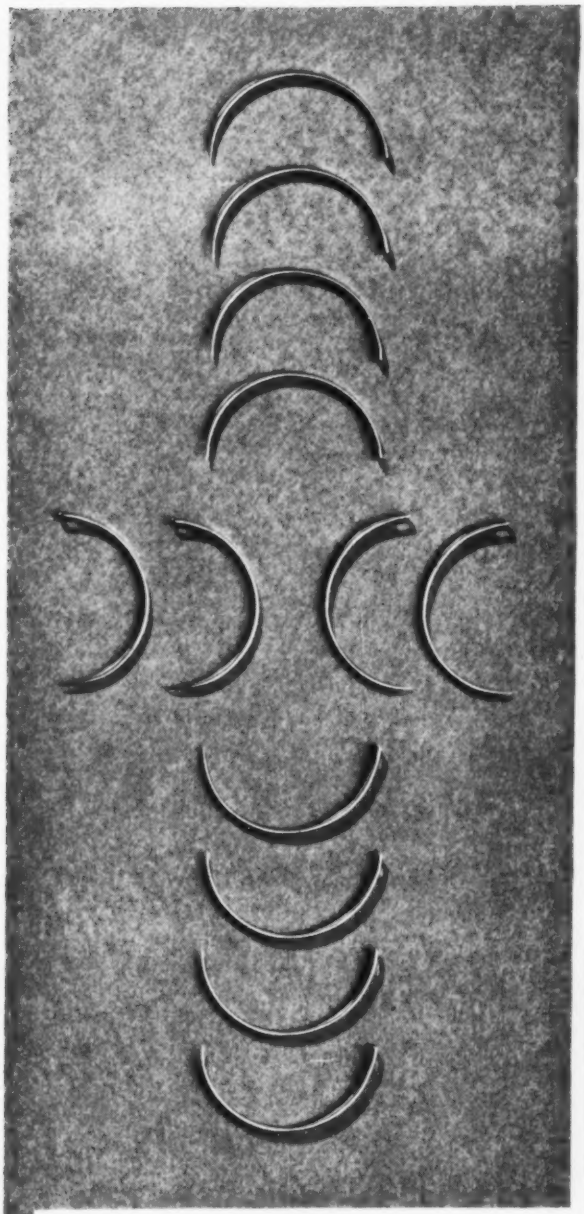
The name *Deknatel* has been recognized as the Yardstick of Quality in surgical silk for more than 20 years. The reason for this lies in the unusual tensile strength of the suture material — the constant uniformity of diameter — and its extreme pliability. Deknatel Surgical Silk is moisture and serum resistant — non-absorbable, non-capillary, and non-slipping. The unvarying quality and uniformity of Deknatel Sutures have won the confidence of surgeons everywhere. J. A. Deknatel & Son, Queens Village 29, L. I., N. Y.

Sold by Surgical-Hospital Supply Houses.

DEKNATEL SURGICAL SUTURES

The First and Still The First

OTHER DEKNATEL PRODUCTS—DEKNATEL SURGICAL NYLON, MINIMAL-TRAUMA NEEDLES WITH ATTACHED SUTURES, NAME-ON BEADS



SPECIALLY SELECTED STEEL

insures dependable performance

TORRINGTON stainless steel surgeons needles

Order from your hospital supply dealer. Catalog on request.

THE TORRINGTON COMPANY, Torrington, Conn.

Specialists in Needles since 1866

FOR PROLONGED ANTIBACTERIAL ACTION ON DISINFECTED SURFACES

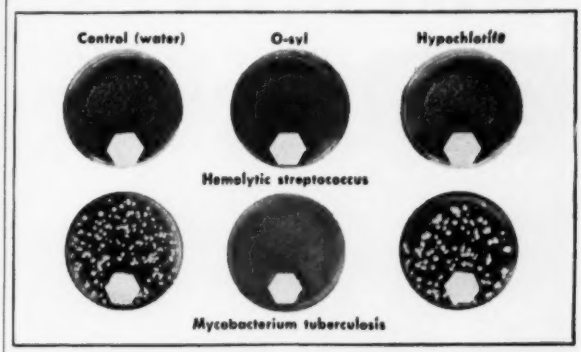
Now — safer, surer procedures are possible in the control of cross infection — without unpleasant disinfectant odor

Proved in hospital use against contagion-spreading germs, including the "secondary invaders" (e.g. M. tuberculosis, Streptococcus pyogenes and others), the nonspecific disinfectant action of O-syl is further enhanced by its *prolonged* antibacterial effectiveness on disinfected surfaces.

Recent scientific tests show that O-syl retains its germ-killing power on surfaces for a *full week*. This contrasts with such disinfecting agents as the hypochlorites whose antibacterial action is dissipated after approximately 1 hour.

Odorless and harmless, O-syl combined with water cleans, disinfects and deodorizes. It can be used with soaps and detergents without loss of effectiveness against bacteria and fungi.

Full information is available to physicians and hospital personnel, free, upon request.



These photographs demonstrate the continuing antibacterial potency of O-syl. Sterilized porcelain hexagons, of the type used in bathroom flooring, were washed with water (left), with O-syl solution (center), and with hypochlorite solution (right). Later the hexagons were contaminated with the bacteria indicated. The antibacterial effect of the hypochlorite solution was no longer in evidence 2 hours after the application. The O-syl solution remained effective for 1 week, at which time the observation was terminated.

O-syl®
Brand Disinfectant

Lehn & Fink Products Corporation, 445 Park Avenue, New York 22, N. Y.
Or your surgical supply dealer

classified advertising

POSITIONS OPEN

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 125-bed new hospital under construction; midwest. (b) 185-bed hospital, graduate staff, Ohio. (c) 50-bed West Virginia hospital. (d) 60-bed Oklahoma hospital.

NURSE ADMINISTRATORS—(a) 65-bed hospital; Ohio; $5000. (b) 32-bed hospital, New England. (c) 50-bed hospital, New York state; $5200.

ASSISTANT ADMINISTRATORS—(a) Maintenance supervision; 200-bed midwestern institution; $5000. (b) 275-bed chronic hospital, east. (c) 275-bed hospital, Pennsylvania.

COMPTROLLER—300-bed eastern hospital.

DIRECTORS OF NURSING—To $6000, maintenance.

HOUSEKEEPERS—(a) Male or female; 300-bed eastern hospital. (b) 500-bed midwestern hospital.

INTERSTATE—*Continued*

INSTRUCTORS—Collegiate schools; $4500.

OCCUPATIONAL THERAPIST—Michigan.

PERSONNEL DIRECTORS—(a) 350-bed hospital, midwestern university city. (b) Credit manager; 200-bed Sisters' Hospital, central state. (c) Office manager; 125-bed Kansas hospital.

PHARMACISTS—$350-$450.

TECHNICIAN—X-ray; $375; Ohio.

PLACEMENT BUREAUS

CALIFORNIA AND WEST COAST
Complete Coverage
Hospitals—Clinics
Excellent Openings—Confidential Services
CONTINENTAL MEDICAL BUREAU, Agency
510 West 6th Street, Los Angeles 14

PACIFIC COAST MEDICAL BUREAU,
Agency
703 Market Street, San Francisco 3

(Continued on page 224)

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11 West 42 Street New York 36, N. Y.
Mary A. Johnson, Ph.D., Director
FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

EVERY SECOND LOST

200 COULD HAVE LOST A HUMAN BEING

CHILDREN SAFELY ESCAPED RAGING FIRE



HOSPITALS AND INSTITUTIONS
Equipped with POTTER SLIDE TYPE ESCAPES provide the *SAFEST* and *QUICKEST* method of evacuating Patients, Nurses, Internes, Doctors and Attendants. Write for details.

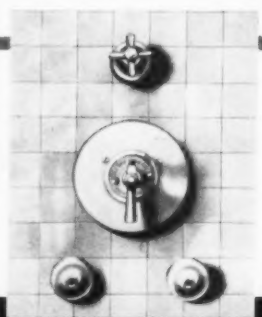
Over 9,000 in service on two to 34 story buildings, saving 44 sq. ft. of usable floor space on each floor instead of stair wells.

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6118 N. California Ave. CHICAGO 45, ILL.
For QUICK DETAILS, PHONE COLLECT (ROgers Park 4-0098)

LEONARD
Reg. U.S. Pat. Off.
Thermostatic
WATER MIXING VALVES

Celebrating our 40th Anniversary 1913-1953

The Standard of Excellence for SHOWER MIXING VALVES



For accurate control of showers, sitz baths, X-ray sinks, arm and leg baths, in fact *wherever water temperature is to be controlled*, there is a LEONARD VALVE "Designed for the Installation."

Write for Catalog K

Representatives in Principal Cities

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1360 Elmwood Avenue, Cranston 7, R. I.



AIR CONDITIONING SPEEDS RECOVERY!

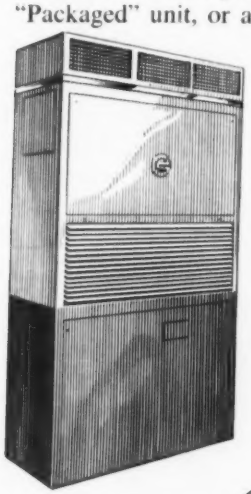
Individual rooms, whole wings, or a complete hospital can be kept cool and comfortable when equipped with Chrysler Airtemp Air Conditioning. Patients rest easier—feel better—recover faster—in such a relaxing atmosphere.

But that's not all! In the operating rooms, air stays cleaner—healthier. Doctors feel more relaxed when humidity and temperatures are controlled.

That's why so many modern hospitals are turning to Chrysler Airtemp Comfort Zone Air Conditioning. They know it's a wise investment for the years ahead. Whether it's a Room Cooler, a "Packaged" unit, or a radial unit for a whole hospital . . . you know you're getting the best in Air Conditioning. The Chrysler Airtemp name is your assurance that every unit is precision engineered and manufactured for long trouble-free life.

Comfort Zone



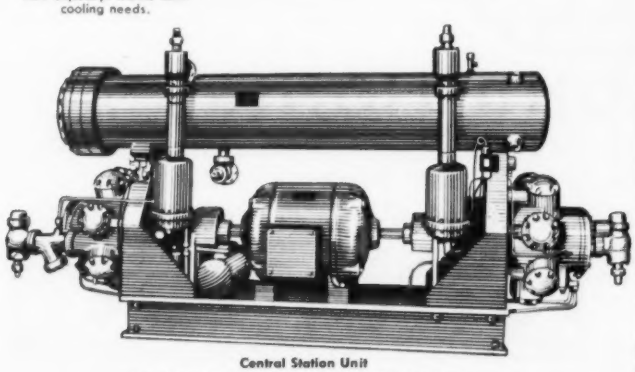


"Packaged" Air Conditioners
Six models from 2 to 15 H.P. capacity. Meets most cooling needs.



Room Air Conditioner
Fits in window, cools, filters, circulates fresh outside air.

Guaranteed by Good Housekeeping



Central Station Unit
The efficient "heart" of larger air conditioning systems.

Chrysler Airtemp

HEATING • AIR CONDITIONING
***for* HOMES, BUSINESS, INDUSTRY**
Airtemp Division, Chrysler Corporation, Dayton 1, Ohio

Airtemp Division, Chrysler Corporation MH-3-53
P.O. Box 1037, Dayton 1, Ohio

I'd like to know more about Chrysler Airtemp Air Conditioning.

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PLACEMENT BUREAUS

HOSPITAL PERSONNEL BUREAU

Charles J. Cotter, Director
(Licensed Employment Agent)
Professional Arts Bldg.
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Telephones: Office—950; Res.—2885

Positions available, most areas, Administrators, Pathologists, Anesthetists, Pharmacists, Housekeepers, Technicians, Dietitians, Librarians, Director of Nurses and all nursing positions. Send resumé, 10 snapshots, date available.

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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

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BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
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If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

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Opportunities in most areas for Medical Directors, Administrators, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Technicians, Therapists, Librarians and all areas of Supervisory hospital personnel.

MISCELLANEOUS

FOR LEASE: 29-patient Nursing Home. Fully furnished. To Qualified Nurse, for $2,400 cash and $800 monthly rental. Write B. B. Carlton, Gadsden, R.I., Alabama.

(Continued on page 226)

HOSPITAL SALES EXECUTIVE

Leading national manufacturer of metal hospital furniture requires an experienced man to head its national sales organization for the hospital field. Unusual sales executive opportunity with well established, nationally recognized manufacturer. Headquarters in Chicago.

Applicant must have thorough knowledge of and experience in hospital field. Please state in first letter full details of experience, age, education, family, income requirements. All replies will be held fully confidential.

Reply, MHO 51, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

FOR SALE

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.



UNIT AIR CONDITIONERS

Are now available in three sizes—3, 5 and 7½ horsepower. These superior Units have extra-large refrigerating surfaces: they deliver more cooling effect per dollar, and we can prove it! Built into them are 70 years' experience.

Get the full facts on Frick Units before you buy: write for Bulletin 522. If you need a still larger air conditioning system, ask for Bulletin 504. Branches and Distributors in principal cities, the world over.

DEPENDABLE REFRIGERATION SINCE 1882
FRICK CO.
WAYNESBORO, PENNA. U.S.A.

Also Builders of Power Farming and Sawmill Machinery

A Collectors' Item



. . . and no pun intended

WITT CAN users occasionally send us letters, postcards—yes, even birthday cards telling us about the wonderful condition of their twenty to thirty year old WITT CANS.

Hard day in and out usage rather than esthetic appreciation prompts the purchase of WITT CANS—yet the comments we receive indicate a pride of possession that bears investigation.

Perhaps you are wondering why WITT CANS last so long. Here are just a few reasons:

STRAIGHT SIDES—assure extra resistance to rough handling.
DEEP ROLLING CORRUGATIONS—run full length of Can, adding further rigidity.
HEAVY GAUGE STEEL—provides battleship ruggedness.
STRUCTURAL STEEL BANDS—protect top and bottom of Can and act as shock absorbers.
HOT DIP GALVANIZING—a hand process after fabrication, insuring heaviest possible rustproofing.
PINCH-PROOF HANDLES—for easy handling.
STURDY LID—snug fitting, yet easy to remove.

WITT CANS HAVE THE "RIGHT" ANGLE



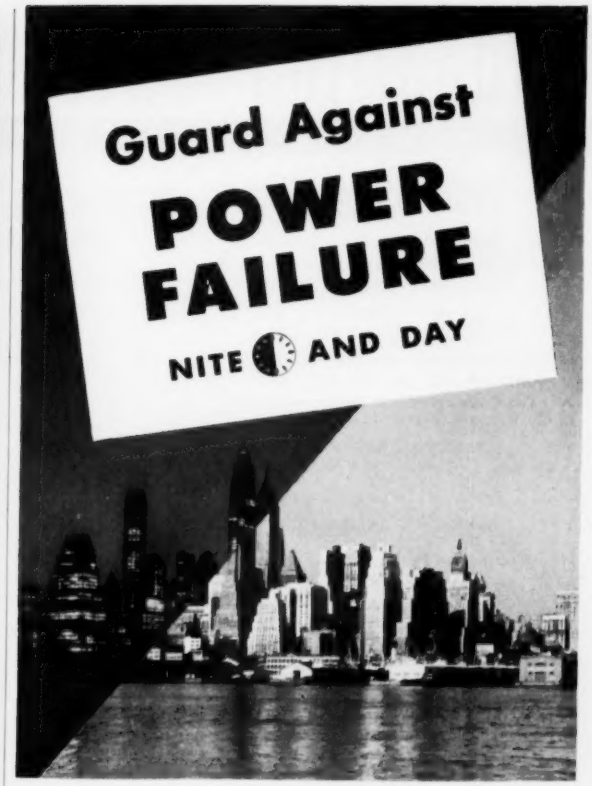
Witt Cans

"Originators of the Corrugated Can"

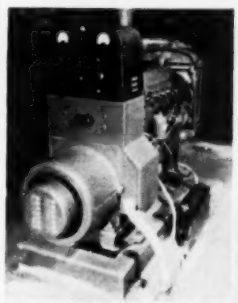
THE WITT CORNICE COMPANY
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CINCINNATI 14, OHIO

Guard Against POWER FAILURE

NITE AND DAY



Do you face the risk of endangering lives or losing time and money in event of sudden power failure? Be *sure* you're adequately prepared for such an emergency by installing dependable Ready-Power Standby Equipment. Then when commercial failure *does* occur, your Ready-Power Equipment automatically "takes over" and assures continuation of vital services at any time of night or day. Ready-Power engine generators can fulfill practically any standby requirement including civilian defense needs. They operate on a wide choice of fuels.





Ready-Power safeguards plant life in this conservatory

READY-POWER

ENGINE GENERATORS

Write for complete information.

THE READY-POWER CO. • 11231 Freud Ave., Detroit 14, Mich.

Manufacturers of Gas and Diesel Engine Driven Generators and Air Conditioning Units; Gas and Diesel Electric Power Units for Industrial Trucks.

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FOR SALE

For Sale: Used surgical operating tables, obstetrical tables and bassinets.

METHODIST HOSPITAL
Peoria, Illinois

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

Neatly bound volumes of

(1) The MODERN HOSPITAL—62 volumes—16 to 77, for the years 1921 to 1951, indexed.

(2) HOSPITALS—27 volumes—for the years 1936 to 1951, indexed.

Price, $10 per volume

Reply, MS 52, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SCHOOLS—SPECIAL INSTRUCTION

CEREBRAL PALSY INSTITUTE
JUNE 29-JULY 10, 1953

The Coordinating Council for Cerebral Palsy in New York City, Inc., announces its third professional Cerebral Palsy Institute for qualified physicians, nurses, physical, occupational, speech therapists, social service guidance workers and teachers.

The Institute this year will be pointed up to the related problems in the area of speech disabilities relative to the cerebral palsied, and will be given in cooperation with the Speech and Hearing Department at Brooklyn College, Brooklyn, New York.

Eminent lecturers, authorities in their field, will participate. The Institute will include lectures, clinical demonstrations, movies and seminars.

For further information write to Miss Marguerite Abbott, Executive Director, Coordinating Council for Cerebral Palsy, 509 Madison Avenue, New York 22, New York.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

TOO LATE TO CLASSIFY

POSITIONS OPEN

DIRECTOR OF NURSES—New 50-bed general hospital, under construction; pleasant community, excellent recreational facilities; 32 miles to Milwaukee; 40-hour week; good personnel policies; supervisory experience required; salary good. Apply, Memorial Hospital, Oconomowoc, Wisconsin.

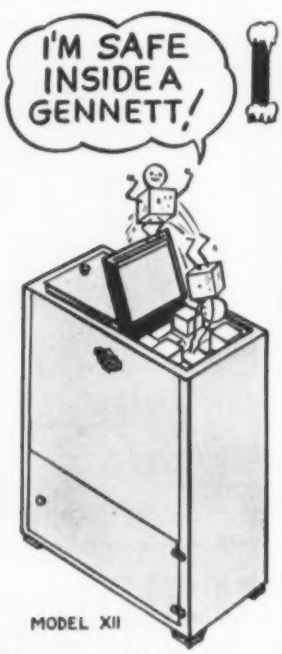
INSTRUCTOR—Nursing arts; immediate opening in 100-bed general hospital with fifty students; college in hospital vicinity; about 40 miles from Boston; 40-hour week; salary open; B.S. Degree required. Contact Director, School of Nursing and Nursing Service, Nashua Memorial Hospital, Nashua, New Hampshire.

SALESMAN Surgical supply; to live in Shreveport, Louisiana; must be experienced in selling equipment and supplies to doctors and hospitals. Reply by letter, stating experience, age, salary, and including recent photo: Box 706, Shreveport, Louisiana.

SUPERVISOR—Clinical; immediate opening in 100-bed general hospital with fifty students; college in hospital vicinity; about 40 miles from Boston; 40-hour week; salary open; B.S. Degree required. Contact Director, School of Nursing and Nursing Service, Nashua Memorial Hospital, Nashua, New Hampshire.

MISCELLANEOUS

FOR LEASE—30-patient nursing home; $5000 cash, lease 600 months; rentals; Michigan. ML 101, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.



ICE...

crushed
cracked
cubed
IS

SAFE AND SANITARY..

...when it's inside the GENNETT MODEL XII Stationary Ice Storage Cabinet.

22-Gauge
STAINLESS STEEL
Throughout

100-LB. CAPACITY
37¾ inches High
23¾ inches Wide
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MODEL XII

Other Models Available
Write for Free Catalogue

EASY-TO-USE Drip Door
Drip Bucket Included

GENNETT & SONS, INC.
No. 1 Main Street • Richmond, Indiana

Day-Brite Bed Lamps . . . Keyed to modern hospital design . . .



"DECIDEDLY BETTER"
DAY-BRITE
Lighting Fixtures

THIS Day-Brite Bed Lamp was designed and built for just one purpose—*to give you the finest patient room lighting your money can buy.*

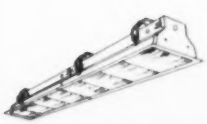
Mount this 3-lamp direct-indirect unit about 7 feet up on the wall at the rear of the patient's bed. A pull switch drops down so that the patient can control direct illumination from the middle lamp for reading or writing. No effort or movement involved—no need to call the nurse.

Soft, indirect general lighting is furnished by the two end lamps and is controlled by the nurse from a wall switch beside the door. Both direct and indirect illumination are diffused to eliminate glare and make your patient more comfortable.

The stainless steel finish is extremely easy to keep clean. The Day-Brite Bed Lamp is ventilated top and bottom for safe operation and is approved by the Underwriters' Laboratories.

Write for full information about this specially designed hospital fixture. Find out how you can improve your patient room lighting at a reasonable cost. Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Missouri. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario. 347

OTHER DAY-BRITE HOSPITAL LIGHTING FIXTURES



DAY-BRITE TROFFERS



NITE LITE



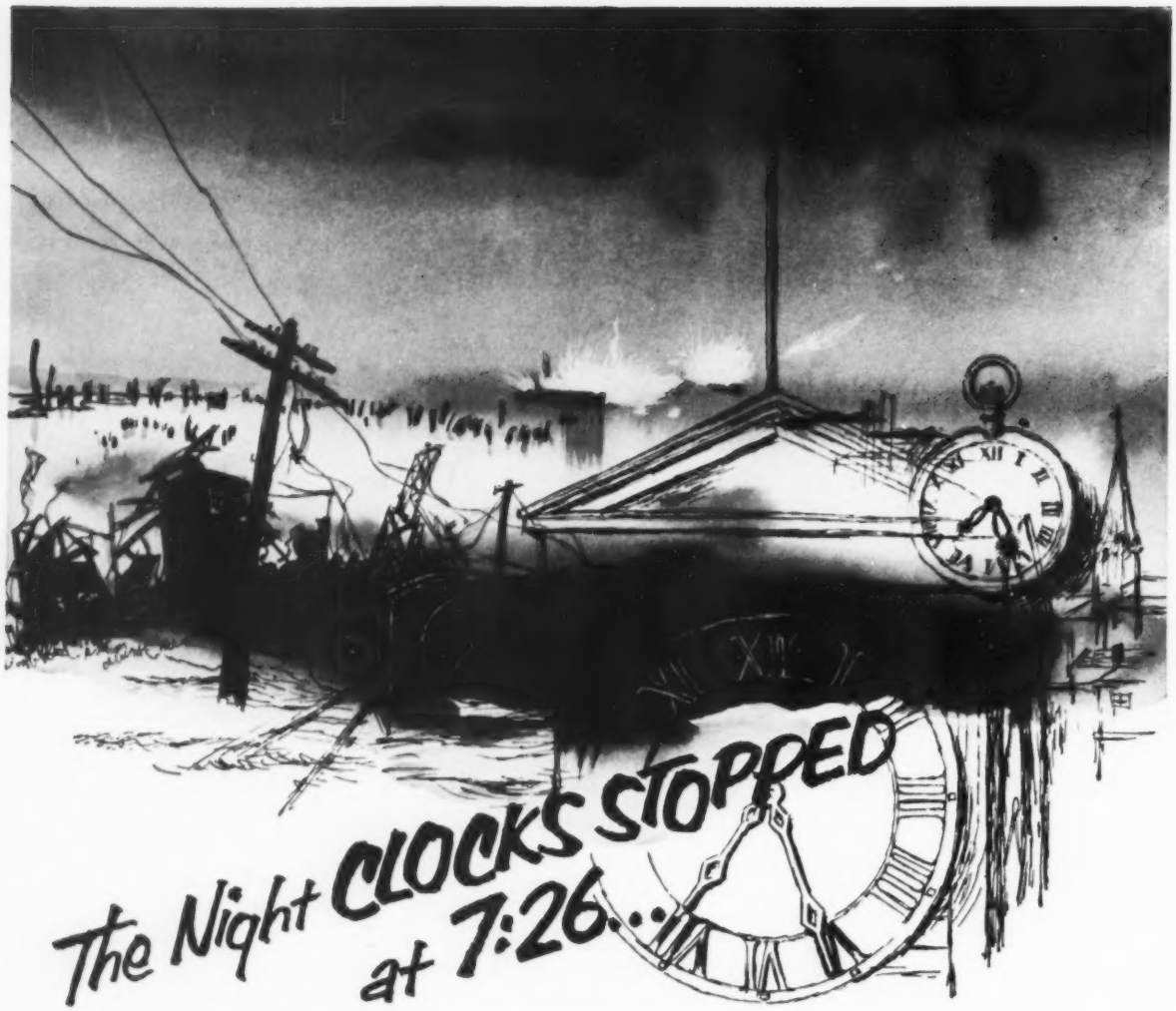
LUVEX®



EXIT SIGNS



PLEXOLINE®



Some 9,500 people were in South Amboy, N. J., that drizzly evening in 1950. At the waterfront, longshoremen were transferring the last of 12 freight cars of ammunition to lighters that would carry it to a waiting vessel in Raritan Bay.

But the City Hall clock never got to 7:27—and the freighter's deadly cargo never got loaded. Explosions shattered windows over a radius of 12 miles; and hundreds of people looked at their arms and legs and saw that flying daggers of glass had stabbed them.

At dawn, 312 of the injured had been counted.

★ ★ ★

Such disasters have happened many times before in America. They could happen again. And *if* they do—and *when* they do—there must be blood plasma on hand to take care of the injured. For blood saves lives!

But blood cannot be mined or manufactured. It must come from the veins of healthy men and women. Men and women who feel concern for a suffering neighbor. So give blood—now!

Whether your blood goes for Civil Defense needs, to a combat area, or to a local hospital—this priceless, painless gift will some day save an American life!

Give Blood Now

CALL YOUR RED CROSS TODAY!

National Blood Program

Business Executives!

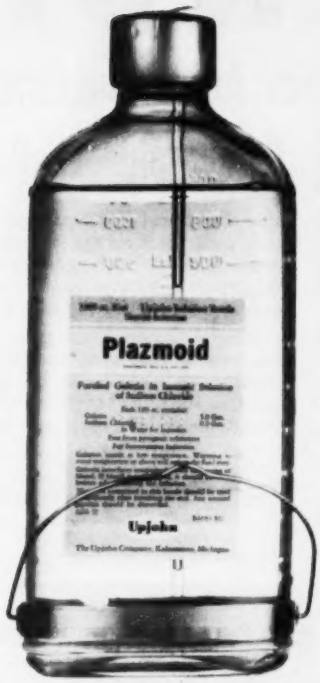
✓Check These Questions!

If you can answer "yes" to most of them, you—and your company—are doing a needed job for the National Blood Program.

- ☐ Have you given your employees time off to make blood donations?
- ☐ Do you have a Blood Donor Honor Roll in your company?
- ☐ Have you set up a list of volunteers so that efficient plans can be made for scheduling donors?
- ☐ Have you arranged to have a Bloodmobile make regular visits?
- ☐ Has your management endorsed the local Blood Donor Program?
- ☐ Have you informed employees of your company's plan of co-operation?
- ☐ Was this information given through Plant Bulletin or House Magazine?
- ☐ Has your company given any recognition to donors?
- ☐ Have you conducted a Donor Pledge Campaign in your company?

Remember, as long as a *single* pint of blood may mean the difference between life and death for *any* American . . . the need for blood is *urgent!*

Upjohn



hepatitis-free
blood plasma
substitute:



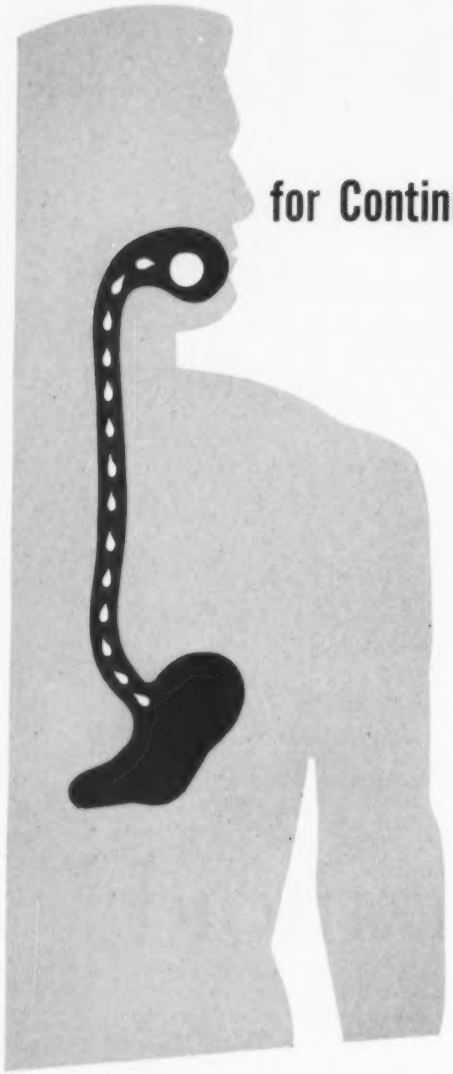
Plazmoid

Trademark Reg. U.S. Pat. Off.

Plazmoid is purified gelatin in isotonic solution of sodium chloride. It parallels plasma in colloidal osmotic effects, yet is much less expensive, and free of the possibility of transmitting serum jaundice.

Available in bottles of 500 and 1,000 cc.

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



Nulacin

for Continuous Acid Neutralization in Peptic Ulcer

Comparable to Drip Therapy

For the hospitalized patient with peptic ulcer, Nulacin tablets present a distinct advancement in therapy. They achieve continuous neutralization of the gastric contents — the *sine qua non* of successful peptic ulcer treatment — with a new simplicity and convenience appreciated alike by patient and hospital personnel.[1,2]

Placed between the gum of the upper jaw and the cheek, and allowed to dissolve, the Nulacin tablet slowly releases its acid-combining ingredients. Thus its maintained antacid effect is comparable to that of continuous intragastric drip, but is free from the disadvantages and inconveniences of the latter.

Lozenge-shaped and of proper hardness for convenient retention in the buccal sulcus, each Nulacin tablet is prepared from milk combined with dextrins and maltose and incorporates:

Magnesium trisilicate	3.5 gr.
Magnesium oxide	2.0 gr.
Calcium carbonate	2.0 gr.
Magnesium carbonate	0.5 gr.
Ol. menth. pip.	q.s.

The tablet is unusually palatable and each tablet provides approximately 11 calories.

For the treatment of active ulcer, the patient should be instructed to suck Nulacin tablets, two or three every hour, beginning one-half to one hour after each meal. The efficacy of the tablet is greatly reduced if it is chewed and swallowed.

Nulacin is available in tubes of 25 tablets through all service drug wholesalers.

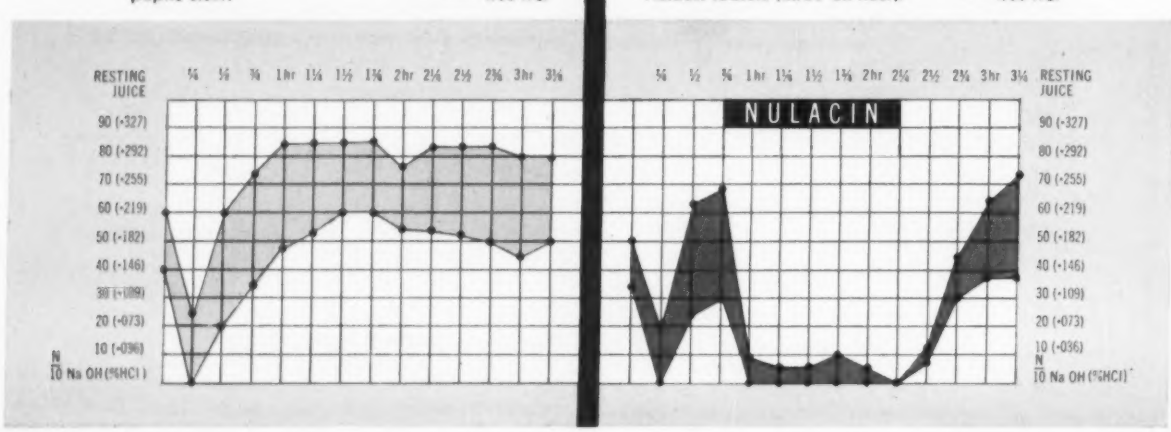
1. Douthwaite, A.H., and Shaw, A.B.: The Control of Gastric Acidity, Brit. M.J. 2:180 (July 26) 1952.
2. Douthwaite, A.H.: Medical Treatment of Peptic Ulcer, M. Press 227:195 (Feb. 27) 1952.

HORLICKS CORPORATION • Pharmaceutical Division

Racine, Wisconsin

GASTRIC ANALYSIS. Superimposed gruel fractional test-meal curves of five patients with peptic ulcer. —— free HCl

GASTRIC ANALYSIS. Same patients, two days later, showing the neutralizing effect of sucking Nulacin tablets (three an hour). —— free HCl

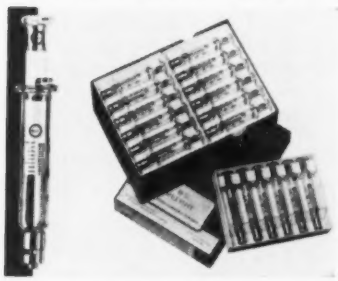


What's New for Hospitals

JUNE 1953 Edited by BESSIE COVERT

To HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 256. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Interchangeable Syringe



The new B-D Multifit is a syringe with interchangeable parts and clear glass barrel. It is the result of years of research and development to meet a long-standing need and to effect substantial savings to the hospital. The new syringes can be quickly reassembled, replaced and cleaned. Replacement costs following breakage are lowered and the high speed reassembly of parts after use and cleaning saves time.

The new Multifit syringes apply the Becton, Dickinson principle of unground, molded clear glass barrels to preserve the protective "skin" of the glass and to ensure maximum service. The new product meets the same high standards for performance and durability as an individually ground and fitted B-D syringe. The first Multifit introduced is the two cc. size which is packed three dozen to the box. Additional sizes will be available later. **Becton, Dickinson & Co., Dept. MH, Rutherford, N. J. (Key No. 848)**

Bolta Wall Tile and Rolls

Up to six times thicker than ordinary waterproof wallpapers, the new surfaced-textured Bolta wall covering is easy to install. It is available in two forms, eight inch square Bolta Wall-Tile and Bolta-Wall rolls. It is made of dimensionally stable material to resist shrinking and gaping seams and resists scuffing, snagging, moisture and stains.

Two attractive surface textures in a wide variety of colors are offered in the new product: Bamboo and Leather-Grain Finish. The semi-flexible wall covering consists of an outer layer made of Vinylite resins laminated firmly to a rubber-saturated paper backing. It can be wiped clean with a damp cloth or sponge and does not support combustion. It cuts cleanly in installation and folds easily around sharp inside or outside corners. The product is the result of several years of research and experimentation by the company. **Bolta Products Sales, Inc., Dept. MH, Lawrence, Mass. (Key No. 849)**

Utility Tray and Cart

The new all-welded stainless steel hospital utility tray has been developed to fit on most hospital carts. Each tray has a special elevated rack designed to hold 29 one-ounce oral medication glasses and



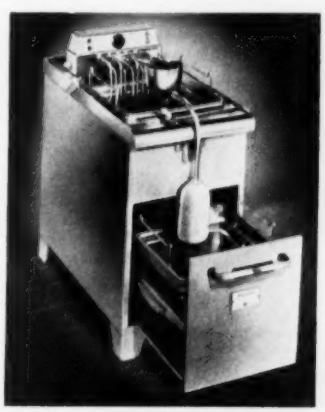
has recessed slots for positive patient identification and dosage cards. The tray is light in weight and ruggedly constructed. It can be easily lifted, carried or stored, or it can be placed on a standard cart when dispensing medications to patients. Glassware and stainless steel utensils are optional equipment. **Continental Hospital Service, Inc., Dept. MH, 18636 Detroit Ave., Cleveland 7, Ohio. (Key No. 850)**

Mark 313 Deep Fryer

Features which save time and materials in deep fat frying, and which improve the flavor of the foods, are incorporated in the Mark 313, the new deep-fat frying machine recently introduced. The new fryer received its name because it can turn out 313 two ounce servings of French fries in an hour, in only 28 pounds of cooking fat. It requires a preheating period of only five minutes and has virtually instantaneous temperature recovery.

Every joint of the fry baskets is welded to prevent the collection of food and fat, for ease of cleaning, and to prevent the possibility of fat remaining and becoming rancid. The removable fat compartment, which can be washed like an ordinary kitchen utensil, has valveless construction with completely unobstructed interior and rounded corners for easy cleaning. A duplicate fat compartment is stored in a roller-bearing drawer below the cooking section. At the end of the day, the tilt-type heating element is swung upright where it drains and can be easily cleaned, the drawer is pulled out, revealing the reserve fat container, and the "Miraclean" drain-and-strain apparatus siphons the fat into the clean container for storage. The used container is lifted out and washed with the fry baskets while the second container with the fat is placed in position, ready for use.

The new, more powerful Calrod heating element ensures quick preheat and fast cooking. The coils circle the inside of the fry kettle section, heating the cooking fat from all sides at once and maintaining an even, uniform heat distribution without any waste of heat. The cooking heat is held to the proper heat by an accurate thermostatic control, preventing the fat from getting too hot.



Signal lights indicating stages of operation and a safety switch are features. **Hotpoint Co., Dept. MH, 227 S. Seeley Ave., Chicago 12. (Key No. 851)**

(Continued on page 232)

What's New . . .

Stryker Cast Spreaders



The new Stryker Cast Spreaders are designed to simplify the removal of casts. The thin, inter-digitated teeth can be inserted into the narrow saw slot made by the electric Cast Cutter. The teeth are made of a special alloy steel, properly hardened to prevent breaking or bending, and the spreaders are rugged and durable.

The spreader is available in two sizes, the heavy duty model 83 with powerful four to one leverage ratio and jaw spread adequate to open the largest body cast, and the regular duty model 82 which can be used with one hand in removing smaller casts. Its four to one leverage ratio provides a powerful jaw opening up to one inch. Both models have self-gripping, serrated teeth faces and are chromium plated. The rounded nose behind the teeth prevents the blade from advancing into the plaster and pinching the skin. **Orthopedic Frame Co., Dept. MH, Kalamazoo, Mich. (Key No. 852)**

Lotocreme Massage Lotion

Lotocreme Massage Lotion is a soothing, non-greasy body rub leaving the skin cool and refreshed. It is a white, stable oil-in-water perfumed emulsion containing alcohol plus lanolin, olive oil, glycerine and methol. It is well absorbed and will not stain clothing or bed linen. It is supplied in Abbott's "easy-grip" bottles in 8 fluid ounce sizes. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 853)**

Coated Concrete Block

Kem-Krete is a new type of coated concrete block, in either glazed or textured finish, with built-in color. It offers a colorful new construction material for interiors of all kinds. These standard masonry construction units are pre-coated to provide structural strength and finished surface in a single unit. The Kem-Krete finish becomes locked to the concrete block through a chemical action that transforms the finish into an integral part of the block in the manufacturing process. Thus a finished wall is provided in one operation. It is an improved, permanent type of surface for interior walls, eliminating the need for special facing materials and repeated refinishing.

The precoated blocks are available in 20 standard colors. The glazed finish presents a smooth, unbroken film over the entire surface of the block which is waterproof and impervious to washing compounds and cleaning materials. The textured finish retains the acoustical properties of unfinished concrete. **The Sherwin-Williams Co., Dept. MH, 101 Prospect Ave. N.W., Cleveland 1, Ohio. (Key No. 854)**

Lawn Care Attachments

Attachments have been developed for the Model 728 Snow Thrower which make this a year-round utility machine. The snow thrower unit is easily removed, leaving a powerful tractor unit



with a transmission giving three forward speeds and reverse. Available for lawn and grounds care with this unit are a 72 inch mower, a 38 inch rotary mower, a lawn roller, a 42 inch dozer blade and a ½ ton dump trailer. This versatile unit, with 7½ h.p. engine, now offers complete facilities for lawn and ground care in all seasons. **The Maxim Silencer Co., Dept. MH, 85 Homestead Ave., Hartford 1, Conn. (Key No. 855)**

Quick-Change Mop

The Green Dragon mop has a new design for quick mop changes. The new attachment device is a simple slide and two hooks which permit quick and easy removal or change of mop heads without handling strands. The construction eliminates exposed hardware at corners, permitting faster work in narrow spaces and corners, without danger of damaging woodwork. The 8 ply yarn used in the new mops gives greater durability and absorbency. A green thread runs through the strands to identify the Green Dragon mops. **Edward Don & Co., Dept. MH, 2201 S. La Salle St., Chicago 16. (Key No. 856)**

(Continued on page 234)

Room Air Conditioner

A new ½ h.p. Vornado Air Conditioner for small areas has been introduced. The unit cools, ventilates, circulates, dehumidifies, filters and exhausts the air. Its Vortex Control combines a high velocity discharge of 1500 feet of air per minute with maximum cooling to move cool air up to thirty feet into a room. The air circulator can be rotated 360 degrees and tilted up or down to direct air to any area in the room. Draft free air movement penetrates all parts of the room.

The Variable Cooling Control feature allows gradual regulation of cooling capacity and allows the unit to remove moisture from the air on humid days even though the unit is operating at lower cooling capacities. The new Model 50 WAC has the Vornado Comfort Selector to adjust the variable cooling controls to fit individual need. The cabinet of modern design has a gray-green finish trimmed in burgundy and gold. The unit can be installed in any double hung sash window from 23 to 48 inches wide. **O. A. Sutton Corp., Dept. MH, Wichita, Kans. (Key No. 857)**

Finger-Flite Typewriter

The new Underwood Finger-Flite Electric Typewriter is designed for functional efficiency and is available in five models. The new Finger-Flite keyboard has keytops of light gray, especially created for speed and finger comfort. Function keys are in dark blue to give instant color control between the operating and feature keys. The top plate has been redesigned to give greater visibility of the writing line and to give the machine a lower appearance. It has a wider writing line margin; a new carriage positioning scale; a three-position paper bail; a new push-in type variable line spacer, and a new impression control dial for automatic selection of the proper key impact for any desired number of carbon copies. It is finished in



soft gray with harmonizing dark blue base. **Underwood Corporation, Dept. MH, 1 Park Ave., New York 16. (Key No. 858)**

NOW...

one nurse can do the work of two





WITH THE NEW "VOKALCALL" AUDIO-VISUAL NURSES' CALL SYSTEM

The new "VOKALCALL" now combines in one nurses' call system all the advantages of natural two-way voice communication between patient and nurse, with all the advantages of the time-tested method of utilizing visual and audible signals to call the nurse. With "Vokalcall" the nurse can talk directly to patients without leaving her station, thereby saving herself countless unnecessary trips to bedsides. With "Vokalcall" the nurse can cancel all visual signals originated by patients' calls at *either* her control station or at patients' bedsides. With "Vokalcall" the nurse can "listen in" to each room at any time (with patient's permission) without leaving her station and without disturbance to anyone.

"Vokalcall" doubles the nurse's effectiveness through saved footsteps, ability to attend more patients, greater concentration on direct bedside care, and increased morale and feeling of accomplishment.

Patients like "Vokalcall" too. They benefit from a feeling of security and their needs are known sooner and met faster. To hospitals the tremendous advantage of greater service, reduced operating costs, and increased goodwill are obvious.

SINCE 1892 AUTH

A new booklet entitled "VOKALCALL" tells the whole story. Write:

AUTH ELECTRIC CO., Inc.

34-20 45th STREET, LONG ISLAND CITY 1, NEW YORK.

What's New . . .

One-Minute X-Ray



The Picker-Polaroid 1-Minute X-Ray, originally developed for military requirements, is now available for civilian hospitals. The unit is suitable for use in operating room, emergency room, and in other areas with portable and mobile units. It is operated by loading the cassette, in a light room if necessary, making the exposure with any x-ray source and then putting the cassette into the processing box. The finished, dry radiograph is ready in one minute. **Picker X-Ray Corp., Dept. MH, 25 S. Broadway, White Plains, N. Y. (Key No. 859)**

Craig Universal Headrest

The new Ohio Model A2096 Craig Universal Headrest is constructed of lightweight anodized aluminum and chrome-plated steel. Multiple friction locks, operated simultaneously, promote ease of positioning and infinite adjustment. The lockable hinge points give excellent stability and the adjustable chin rest and two head-piece pads equipped with a double hinge point and sliding bar give maximum exposure. A variety of parietal approaches is possible with the removable head piece pads, side tilt and lateral mobility. The headrest is supplied with two ⅝ inch round rods for insertion in the knee crutch clamps or for attachment to the back section with special side rail clamps. **Ohio Chemical & Surgical Equipment Co., Dept. MH, Madison 10, Wis. (Key No. 860)**

Magnesium-Front Cassette

The new Magnesium-Front Rigidform Cassette introduced by Halsey is designed to assure perfect film-cassette contact under all conditions. As magnesium is immune to temperature and humidity changes encountered in x-ray work, the new cassette does not swell or buckle even under extreme conditions. It has stress and shock-resistant construction, plus the added strength provided by use of a metal front panel. It also has the Halsey "positact" features including three times the normal number of cross-bar pressure points to apply uniform pressure over the entire cassette to maintain perfect contact. **Halsey X-Ray Products, Inc., Dept. MH, 1425 37th St., Brooklyn 18, N. Y. (Key No. 861)**

Topper Pads

Introduced as an economical post-operative dressing, the new Johnson & Johnson Topper Pad is the result of years of research. The pads are constructed with a gauze covering enclosing a web of cotton and a center filler of soft, absorbent cellulose. They are designed to take the place of gauze or cotton-filmated sponge and the absorbency, capacity and weight are approximately equal to the corresponding sizes. Topper pads are so constructed that drainage is drawn into the center of the pad, keeping the wound area dry. The pads are available in 8 by 4 inch and 6 by 4 inch sizes, packed 100 pads to a bag and 20 bags in a case. **Johnson & Johnson, Dept. MH, New Brunswick, N. J. (Key No. 862)**

Venetian Blind Laundry Unit



A simplified and inexpensive method for cleaning venetian blinds is offered in the new Jetspray Venetian Blind Laundry Unit. The unit can be operated by one individual without special skill and an average sized blind can be cleaned and rinsed in a matter of minutes. The laundry unit can be installed wherever there is a convenient floor drain with space to hang a blind for cleaning.

The Jetspray is designed to clean even the dirtiest blinds without hand rubbing. Tapes, cords and slats are all cleaned in one easy operation without taking the blind apart. **L. C. Robinson Mfg. Co., Dept. MH, 522 N. Rural St., Indianapolis 1, Ind. (Key No. 863)**

Chemical-Resisting Gloss White

Laboratories, kitchens and other areas where corrosive agents are present can be protected with the new Chemical Resisting Gloss White for walls and ceilings. It is formulated on a synthetic rubber base and is designed to resist attack by moisture, grease, chemical fumes and caustic cleaners. **Tropical Paint & Oil Co., Dept. MH, 1246 W. 70th St., Cleveland 2, Ohio. (Key No. 864)**

(Continued on page 236)

Automatic Vegetable Peeler

Gifford-Wood automatic vegetable peelers, in units to peel 15, 30 or 50 pounds of vegetables in 45 to 60 seconds, are now being made available to institutions. The units peel whole potatoes, turnips, carrots and similar vegetables quickly and thoroughly with minimum peeling losses. An automatic shut-off timer ensures minimum waste. The one-piece vegetable hopper has a Cast-In-Carborundum interior surface. The Cast-In-Corborundum process involves a fusing of carborundum and metal in the casting process which produces an abrasive surface of extreme durability. There are no seams or crevices to catch peelings.

Two models are available, the Royal and the Superior. The hopper in the Royal is mounted on a cabinet and may be positioned to discharge vegetables from any side. The peel trap is built into the cabinet and is easily reached for emptying. This model is available in various heights to allow discharge into sinks 32, 34, 36 or 38 inches high. The Superior model is mounted on rugged fabricated steel legs with a drip-proof motor located adjacent to the hopper. The peel trap, if required, is attached to the side of the base. Both models are protected by several coats of special corrosion resistant base paint and finished with a hard gloss enamel. **Gifford-Wood Co., Dept MH, Hudson, N. Y. (Key No. 865)**

Laboratory Hot Plate

Designed primarily for laboratory use, the new Vulcan Laboratory Style Electric Hot Plate can be used wherever this type of heating unit is required. It has a stepless adjustment thermostatic heat control from 150 to 600 degrees F. Any required uniform surface temperature can be maintained by setting the pointer on the dial. The entire unit is of all-steel construction, 3½ inches high, with bright crackle finish. The top is 6 inches in diameter, with heat escape vents



under the rim. The long-lived heating element is jacketed with stainless steel and is replaceable. **Vulcan Electric Co., Dept. MH, Danvers, Mass. (Key No. 866)**

NOW—An Amazing New Microfilm Camera for Hospitals!

The Diebold FLOFILM PORTABLE CAMERA



Scores of hospitals have found that the motorized FLOFILM Portable Camera microfilms their records for only a small fraction of the cost of maintaining files.

Just take a quick look around your hospital and see what an amazing amount of space is occupied by your file cabinets . . . records and data that are probably not looked at for weeks—or even longer!

Think of the many uses to which you could put this space!

Microfilming gives you indexed, quickly available records, accessible every minute of the day or night!

Entirely without obligation, we will microfilm your case records, survey your file and storage needs — and make concrete, down-to-earth recommendations on how you can *save money* and *gain space* in your hospital with the FLOFILM Portable Microfilm Camera.

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Ideal for Hospitals, the Portable Camera microfilms your records at high speed.

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What's New . . .

Spacemaster Folding Doors



Space can be saved in nurses' homes and other housing areas, as well as in certain areas of the hospital itself, with the new Spacemaster Folding Doors which fold against the door casing. The door is carried along the quiet, "Sure Stop" slides and cannot "creep" away from fully open or fully closed positions. The balanced hinge construction at both top and bottom ensures long life and easy opening and closing. The metal track at top is covered when the door is closed, and there is no floor track to accumulate dust and dirt.

Spacemaster Folding Doors have compression springs at the bottom to equalize fabric tension and to keep folds even. They are sturdily constructed and can be installed in a minimum of time by any maintenance man. The vinyl coated fabric covering is durable, fadeproof, and can be cleaned by washing with soap and water. The doors require no painting or other maintenance except occasional washing. They are available in 2 foot 6 inch, 3 foot and 4 foot sizes and can be used as pairs. The use of these folding doors saves space when used between rooms, between room and corridor, for closets and in service areas. **New Castle Products, Dept. MH, New Castle, Ind. (Key No. 867)**

Sof-T-Septic for Diapers

Sof-T-Septic is a combination textile softening and permanent germicidal rinse for laundry use for diapers and infants' clothing. When added to the last rinse of the laundry cycle it deposits a material on the cloth which produces a soft, luxurious feel that eliminates irritation due to harsh cloth. It also tends to neutralize residual detergents or soaps. The active germicide in the product acts to kill or retard the bacteria found in the stool. It reduces ammonia odor in wet diapers, makes diapers easy to pin and smooths out wrinkles. The product is non-toxic. **Marlyn Chemical Co., Dept. MH, 156th & Forsythe, Calumet City, Ill. (Key No. 868)**

Bedside Lamp

An attractive, durable lamp for the bedside table in the patient's room or for use in nurses' homes is now available. The six inch diameter stable base gives the lamp a firm footing and the 12 inch diameter shade effectively shields the light from the face.

The new Emeralite bedside lamp uses one 60 to 75 watt standard bulb, providing indirect light. The lamp is 15½ inches high and has standard brown wrinkle finish. **Emeralite Company, Inc., Dept. MH, 40 Warren St., New York 7. (Key No. 869)**



(Continued on page 238)

"Reason enough for installing a

FAIRBANKS-MORSE STANDBY GENERATING SET"

If lives of children in schools, hospitals, or public buildings are your responsibility, insist that they be protected by a Fairbanks-Morse generating set from dangers that arise from sudden and prolonged power failures.

Fairbanks-Morse offers you generating sets in capacities from 650 to 40,000 watts. The large units are recommended for schools, hospitals, theaters and other places handling large crowds. Smaller sets for police and fire departments also are available. *An illustrated booklet of facts* is yours for the asking. Write Fairbanks, Morse & Co., Chicago 5, Ill.



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BRONZE TABLETS

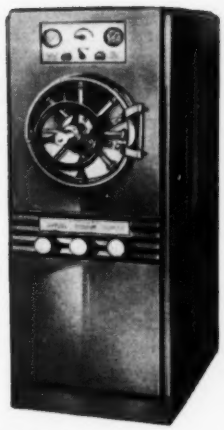
C P
CEREBRAL PALSY CENTER

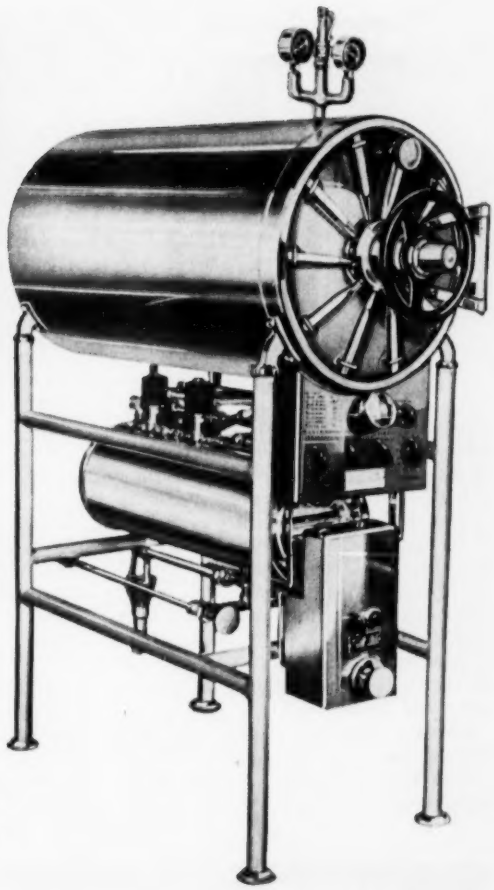
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How Monel cures Sterilizer headaches

Above — New Model A-425 Automatic Instrument Washer-Sterilizer uses Monel for strength, corrosion-resistance. Available for either exposed or recessed mounting.

Right — Scanlan-Morris autoclave-type sterilizer. Available in both direct steam heated or electrically heated models. Scanlan-Morris sterilizers are also available with or without "Steritrol"... automatic control to simplify sterilizing of any type of load to meet your exact requirements.

What is *your* complaint? Stained or unsanitary dressings? Unsightly appearance? Trouble with cleaning?

You'll be interested to learn how Monel® cures these sterilizer ills.

Monel resists the action of moisture, acids, alkalis, and saline solutions. Monel sterilizers do not rust... they keep dressings stain-free.

And because Monel is stronger and tougher than structural steel, it withstands the high temperatures and pressures necessary for maintaining sterile conditions.

Nor does Monel chip, crack or peel. It gives long, trouble-free service.

What's more, Monel is easy to keep clean. Plain soap and water are all that are necessary to keep it bright and shiny as new. And detergents or mild abrasives can't hurt its good looks because Monel is solid all the way through.

Add up the advantages and you'll see why Scanlan-Morris sterilizers are made of Monel. Want more information? Then write for the Scanlan-Morris sterilizer catalog. Address: Ohio Chemical & Surgical Equipment Co., A Division of *Air Reduction Company, Inc.*, 1400 E. Washington Ave., Madison 10, Wis.

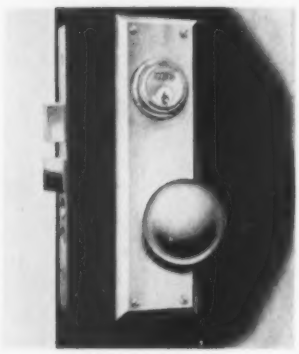
Remember, however, that since Monel is needed for many critical military uses, it is on extended delivery for civilian use. It pays to order your Monel sterilizers well in advance of need. The International Nickel Company, Inc., 67 Wall St., New York 5, N.Y.

INCO TRADE MARK

Monel ...always a name to remember

What's New . . .

Aluminum Hardware



A full line of locks and builders' hardware of aluminum has been introduced by Yale & Towne. The new line consists of high quality pin tumbler mortise locks in four designs, a wide variety of designs of knobs, roses, thumb turn plates, cast and wrought push plates, cast and wrought pulls with plates, pull grips, flush bolts, door stops, letter hole trim and sash fasteners. Brass bolts, screws and cylinder plugs finished in dull chrome will be used with all aluminum locks and hardware.

One size mortise is standard for every type of lock used in the line, thus ensuring easy installation. Special aluminum mortise deadlocks will also be available. Expert master keying service is obtainable throughout the line. **Yale & Towne Manufacturing Co., Dept. MH, Stamford, Conn. (Key No. 870)**

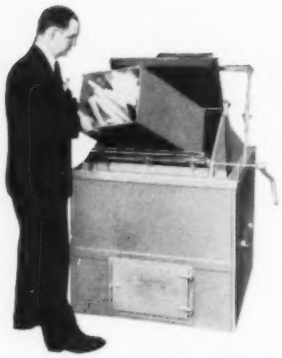
Poly-Krome Asphalt Tile

A new design in asphalt tile flooring, Poly-Krome is described as terrazzo in resilient type tile. Multi-colored chips are set deep into the surface of the tile and retain their brilliance for the life of the floor. Poly-Krome is available in a range of ten colors. **Hachmeister-Inc., Dept. MH, Box 357, Pittsburgh 30, Pa. (Key No. 871)**

Institutional Incinerators

Two new models of the Wincinerator have been announced for institutional and commercial use. These new incinerators are the C-10 with a ten bushel capacity (illustrated) and the C-15 with a fifteen bushel capacity. They are designed to handle wet or dry refuse and are available for a choice of fuel and with special controls. Combustion is complete and practically all smoke and odors can be eliminated.

Oversize feed doors facilitate disposing of refuse. The incinerators are easily



installed and are equipped with safety devices. **Winnen Incinerator Co., Dept. MH, Bedford, Ohio. (Key No. 872)**

Disposable Bed Pads

Five new sizes have been added to the General Cellulose line of disposable hospital bed pads. The new sizes include 17½ by 30, 17½ by 36, 24 by 24, 24 by 30 and 24 by 36 inches. The new sizes are available in the new Chloropad, impregnated with Airkem odor counteractant containing Chlorophyllins and Methyl Benzethonium Chloride, as well as in untreated pads. **The General Cellulose Company, Inc., Dept. MH, Garwood, N. J. (Key No. 873)**

(Continued on page 240)

NEWEST OF THE NEW!

HORNER ANTI-SHRINK HOSPITAL BLANKET CUTS SHRINKAGE 83%

Repeated tests under average hospital laundry procedures prove that the revolutionary new Horner Anti-Shrink treatment process actually reduces blanket shrinkage as much as 83%. Yet, Horner Anti-Shrink Blankets retain their deep, soft nap, "warmth without weight" and original beauty after scores of launderings. They'll help you cut blanket maintenance and replacement costs to the very minimum!

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What's New . . .

Adding Machine



A new type adding machine, in which all the keys are electrified, has recently been introduced. The "Live Keyboard" machine eliminates a large percentage of the hand motions required so that listing of figures and adding them can be done with the minimum of human operations. The machine introduces an entirely new principle in adding machines, according to the manufacturer, as well as new shaped key tops and new colors. The add bar is eliminated as the machine operates instantly by pressing the keys desired. The new machine is available in five different models with 7 column and 10 column keyboards. **National Cash Register Co., Dept. MH, Dayton 9, Ohio. (Key No. 874)**

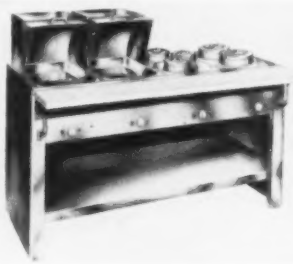
Hood Type Oxygen Tent

The Permatent is a durable oxygen tent constructed of a clear, unusually heavy gauge vinyl plastic, which has extra strength but is transparent and flexible. All parts of the tent are replaceable and entrances to the patient and to the ice compartment are opened by zippers. An adjustable snap fastener type neck collar encloses the adult patient's head comfortably. Two front portholes for the egress of carbon dioxide offer convenience for intubation or admission of increased concentrations of water vapor antibiotics or bronchodilator aerosols. The foundation frame is rustproof welded steel rodding and the tent is simple to operate and easy to clean. **Eliot Medical Plastics, Inc., Dept. MH, 429 Washington St., Lynn, Mass. (Key No. 875)**

Food Serving Table

Cooked meats, vegetables and soups can be kept at the correct serving temperature in the new Model 6914 Star Metal Hot Food Serving Table. Available for gass or electric operation, the table is dry heated and features individual compartments, each with its own three-heat gas burner, pilot and adjustable valve, or five-heat electric unit. The top frame is constructed of heavy gauge, highly polished stainless steel with interchangeable stainless steel top panels designed to permit any desired serving arrangement.

Rounded front corners and an 8 inch wide maple cutting board are features of the base which has adequate insulation to keep fuel consumption at a minimum. The stainless steel roll covers



are designed with a flat top that may be used as a hot serving shelf. **Star Metal Manufacturing Co., Inc., Dept. MH, Trenton Ave. and Ann St., Philadelphia 34, Pa. (Key No. 876)**

(Continued on page 242)

FIND OUT TODAY How You Can Cut Your Maintenance Costs with the 1953 Geerpres Wringers



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Twin "Floor-King" Model Shown

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UTILITY FLOWER TABLE

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★ Perfect for Many Purposes

Whether in lobby, hall, office, reception or guest room, this beautifully designed table is useful and attractive. Three-way stretchers reinforce its sturdy legs, providing great rigidity. Has genuine Woodgrain Formica Top. Equipped with rubber cushion glides.

Natural Birch or Maple finish (Other finishes available). Woodgrain Formica Top, 34" x 14". Height — 29". Weight — 20 lbs.

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The most reliable safeguard against devastating anesthetic blasts in surgical areas is the simple installation of Gold Seal Nairn *Static-Conductive* Linoleum . . . the only linoleum in the world with the remarkable property of *dissipating static electricity* which would otherwise present an explosion hazard.

In addition, Static-Conductive Linoleum delivers *durability and wear-resistance . . . true resilience . . . a sanitary, slip-resistant surface that's easy to maintain* . . . AND the famous Gold Seal *money-back guarantee of complete satisfaction.*

Whatever *your* particular floor covering requirements may be . . . no matter how tough the problem, how tight the budget . . . you'll find the one *right* answer in the wide range of Gold Seal Floors and Walls. Each one of these many Gold Seal guaranteed products is designed to meet a specific, different need . . . to meet it *squarely* and *economically*.

For detailed information write Contract Sales Department:

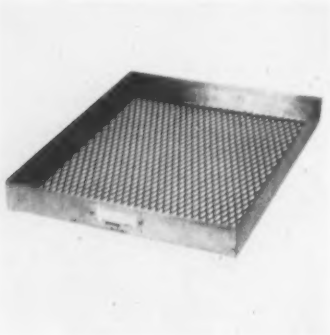
GOLD SEAL FLOORS AND WALLS

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What's New . . .

Biological Tray

Made entirely of stainless steel, the new McCall biological tray is designed to be used in place of a drawer type



container. It is 2 inches in depth and will accommodate small biological bottles. The tray will fit any standard McCall refrigerator and by the use of additional shelves, as many as 24 trays may be used. A safety catch prevents the tray from being pulled more than half-way out as long as it is in contact with the wire shelf. A combination handle and card holder is part of each tray. Trays are easily removed for cleaning. **McCall Refrigerator Corp., Dept. MH, Hudson, N. Y. (Key No. 877)**

Plant Food

Fertileze is the name of a new 14 element water-soluble plant food which has recently been announced. In addition to a 20-10-20 content of the three major elements, Fertileze contains the 11 trace minerals essential for complete plant nutrition. It is packaged in dry powder form and is applied to lawn or garden in solution by means of three special feeding units. **Nutritional Concentrates, Inc., Dept. MH, 3090 W. Liberty Ave., Pittsburgh 16, Pa. (Key No. 878)**

Multiple Beverage Dispenser

The new Sodamaster is a cold drink dispenser from which beverages, plus soda water and cold drinking water can be dispensed from one unit. Each drink has correctly blended flavor, regardless of size, and up to 1800 drinks can be served at 40 degrees or colder. Model SM2H serves two highly carbonated drinks plus soda and cold water. Model SM3H serves three drinks. All models are compact, self-contained units and have rigid steel construction welded throughout, stainless steel top and drain and baked hammerloid gray finish. **Carbonic Dispenser Inc., Dept. MH, Canfield, Ohio. (Key No. 879)**

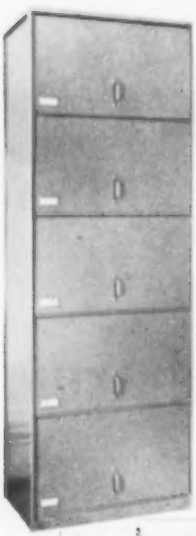
(Continued on page 246)

Swing-Bac Divan

Designed for use in dual-purpose rooms, the Harvard Swing-Bac Divan serves as a comfortable divan during the day and is easily converted for comfortable sleeping. The Bac-Rest swings back with no effort to provide a full 39 inch sleeping surface. When the Bac-Rest is in position, the cushions are supported at the correct depth for comfortable sitting. The all-metal frame is finished in wheat-colored enamel, the legs are completely recessed, and the smooth-rolling casters and easy turning glides make the divan easily moved. It is suitable for nurses' homes and other



housing, especially where rooms are used by meeting, study or social groups. **Harvard Manufacturing Co., Dept. MH, 6201 Woodland Ave., Cleveland 4, Ohio. (Key No. 880)**



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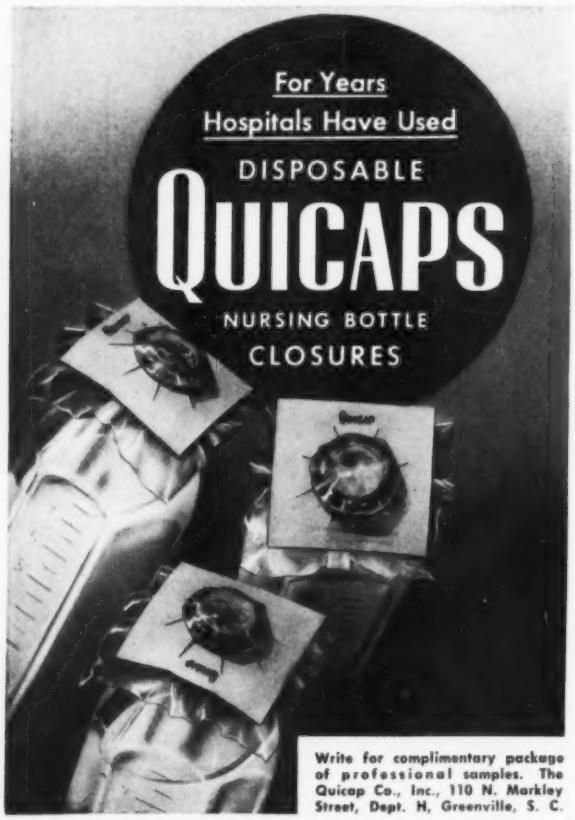
The lightweight drop-door opens quickly and easily revealing all negatives in the compartment.



The patented Facile Guide-Pull "locates" the desired negative providing faster filing service.

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UTICA Muslins are manufactured with constant attention to the most rigid standards of quality. They are made in one of the most modern mills of its kind in the world—to satisfy your standards of quality at the lowest possible cost to you.

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A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

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How Kenwood HOSPITAL Blankets direct from the Mill - save you money!

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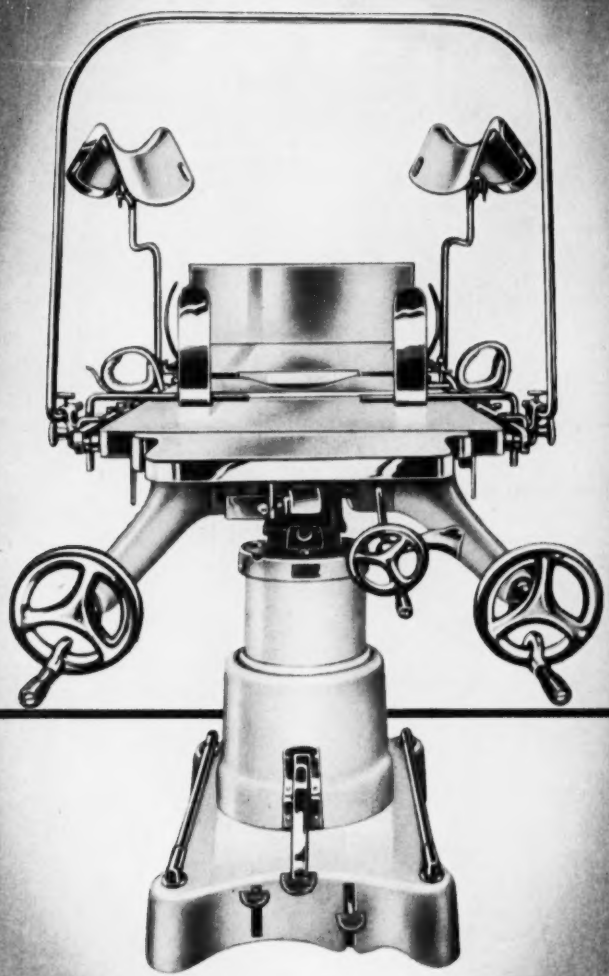
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What's New . . .



Child's Bath Mitt

Bath mitts with faces embroidered in color have been designed for use in pediatric wards. The mitts should also be of interest for sale in hospital gift shops. They are available in a variety of colors with three different face designs. A tape loop at the top makes them easy to hang. The mitts are made of terry cloth, and are packaged singly and in sets of three. **L. Bamberger, Dept. MH, 1 Pinckney St., Charleston, S. C. (Key No. 881)**

"Plastic Lung"

A new light weight "plastic lung" has been developed which sheathes both chest and abdomen. Formed from Royalite styrene copolymer sheeting, the plastic cuirasse has mechanical strength to withstand the pressure changes when air is forced in and out between it and the patient's body. At the same time it has sufficient flexibility to permit an airtight fit to be made. The cuirasse is available in three sizes, for infants, youth and adults. Use of the plastic makes the portable respirator of minimum weight. **Technicon Co., Dept. MH, 215 E. 149th St., New York 51. (Key No. 882)**

Door-Step Threshold

A new Wooster door-step threshold has been introduced with non-slip surface and beveled edges front and back. Known as Wooster Type 115-S, the threshold comes in standard widths of 4, 5 and 6 inches with a maximum length of 6 feet. It is made of abrasive iron and aluminum, also bronze and nickel when permitted. **Wooster Products, Inc., Dept. MH, Wooster, Ohio. (Key No. 883)**

Chart File

The new Visual Indicator Chart File is designed to call the immediate attention of the nurse to new instructions entered by the attending physician on the patient's chart. A red spot next to the name plate shows when the physician makes an entry and moves a tab.

The chart is made of heavy gauge aluminum in all standard as well as special sizes and styles. The name card holder is of stainless steel and extension hangers are covered with rubber. **Beam Metal Specialties, Dept. MH, Long Island City 3, N. Y. (Key No. 884)**

Aluminum Folding Bed

Sturdily constructed of de luxe mirrorized, non-corrosive square aluminum tubing, the All Purpose Folding Bed has Saran plastic covers in a variety of colors in plaid, stripes or solid. The folding bed is easily carried as it weighs only 8½ pounds, and is easy to fold and to unfold into a comfortable temporary bed. Since aluminum does not rust or corrode, the unit can be used indoors or out as an extra, easily set up sleeping accommodation. It folds flat, opens 72 inches long and 28 inches wide, and



requires a minimum of space for storage. **U. S. Chaircraft Mfg. Corp., Dept. MH, 225 Belleville Ave., Bloomfield, N. J. (Key No. 885)**

(Continued on page 250)

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PEQUOT SHEETS & PILLOWCASES

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"Sheets and pillowcases only—for every use"

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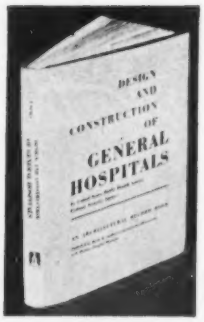
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THE NEW BOOK PREPARED BY

AMERICA'S FOREMOST AUTHORITIES ON

HOSPITAL DESIGN AND ADMINISTRATION



DESIGN AND CONSTRUCTION OF GENERAL HOSPITALS

[a collaborative publishing effort of Architectural Record and The Modern Hospital to present the work of the U. S. Public Health Service]

The last ten years have witnessed such revolutionary progress in medical science that the very basic approach to the design of hospital buildings has been completely changed.

Expanded medical services, new diagnostic, surgical and therapeutic techniques have demanded an entirely new concept of hospital planning.

To meet this challenge, architects, hospital officials and public health authorities working together have evolved far-reaching improvements in design, equipment and facilities.

To examine, interpret, and report these momentous changes, the editorial staffs of two leading professional journals—ARCHITECTURAL RECORD and MODERN HOSPITAL—pooled their efforts with those of the Division of Hospital Facilities, U. S. Public Health Service and the fruits of this effort are contained in this comprehensive new book. This vast fund of planning information has never before been made available in one place.

"Design and Construction of General Hospitals" presents prototypes of successful hospital design, complete with 30 master plans for hospitals of every size. Each plan is accurately scaled, fully detailed, and visualized in a skillful rendering. Illustrations of floor plans, site plans, and a variety of charts and tabular data help to provide step-by-step guidance in the planning—from early sketches to completed buildings—of a modern hospital that truly suits the needs of today's most scientific therapy.

This authoritative volume is certain to win regard as the standard reference work on hospital planning for years to come. It is a source of information and planning data that neither hospital administrators nor hospital architects can afford to ignore.

PARTIAL CONTENTS

SECTIONS

I. SCHEMATIC PLANS OF GENERAL HOSPITALS
30 separate "pilot plans" for hospitals of various sizes, from 20-bed to 400-bed buildings

II. PLANNING THE STRUCTURE

A. Site Selection
- Accessibility
- Public Utilities
- Nuisance Problems
- Orientation & Exposure
- Costs
- Dimensions
- Topography
- Landscaping

B. The Building
- General Considerations
- Traffic: Exterior
- Traffic: Interior

C. Circulation Space
- Corridors
- Stairways
- Elevators

III. ELEMENTS OF THE GENERAL HOSPITAL

A. Main Lobby
- Information & Switchboard
- Admitting Office
- Business Office
- Administrator's Office
- Medical Service Office
- Director of Nurses' Office
- Medical Record Room
- Library & Conference Room
- Staff Lounge and Locker Room
- Gift Shop
- Personal Toilets

B. Nursing Facilities
- Patient Areas
- Two-bed Room
- Four-bed Rooms
- Isolation Units
- Psychiatric Room
- Treatment Room
- Nurses Station
- Consultation Room
- Utility Room
- Floor Pantry

C. Surgical Facilities
- Operating Rooms
- Sub-sterling Rooms
- Scrub-up Facilities
- Clean-up Room
- Anesthesia Equipment Room
- Cystoscopic Room
- Fracture Room (Orthopedic)
- Laboratory
- Darkroom
- Instrument Room
- Surgical Supervisor's Office
- Doctor's Locker Room
- Nurses' Locker Room
- Closets
- Corridor
- Central Supply Facilities

D. Obstetrical Facilities
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- Treatment Rooms
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What's New . . .

Pharmaceuticals

Mebaroin

Mebaroin is a combination of two antiepileptics. It is said to be often more effective and better tolerated than either drug alone. Clinical studies have shown it to control all forms of epilepsy. It is easy to take as it is virtually tasteless and acts without clouding the mental faculties of the patient. It is supplied in bottles of 100 and 1000 scored tablets. **Winthrop-Stearns, Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 886)**

Expandex

Expandex is a plasma volume expander which has been used by the Armed Forces and is now being made available for civilian use. It is designed to prevent and treat shock due to hemorrhage, surgery, injuries and burns and eliminates the danger of infecting patients from plasma or whole blood. It is used in place of plasma but not as a replacement for blood. Use of the product does not interfere with blood typing or crossmatching nor with the functional activity of any organ or tissue in the body. It comes in sterile fluid form, a six per cent dextran solution in isotonic sodium chloride solution, ready for immediate use. It does not deteriorate in storage. **C. S. C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 260 Madison Ave., New York 16. (Key No. 887)**

Gantricillin

Gantricillin is a combination of Gantrisin with penicillin. It is supplied in a scored tablet containing 0.5 Gm Gantrisin plus 100,000 units penicillin G potassium. It is indicated for the treatment of conditions where combined antibiotic and sulfonamide therapy has been found more effective than either alone. It is available in bottles of 24, 100 and 500 tablets. **Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N. J. (Key No. 888)**

Ictotest Reagent Tablets

Ictotest Reagent Tablets are diagnostic tablets for detection of urine bilirubin. The procedure with the tablets is easy to perform and can be carried out anywhere at any time without the preparation of reagents and without corrosive liquids or special equipment. The tablets are supplied in bottles of 90 with test mats. **Ames Company, Inc., Dept. MH, Elkhart, Ind. (Key No. 889)**

Mejalin

Mejalin is a broad sprectrum B complex supplement, containing all 11 identified B complex vitamins, plus liver and iron in balanced amounts. It is supplied in pleasant tasting liquid form and in capsule form. **Mead Johnson & Co., Dept. MH, Evansville, Ind. (Key No. 890)**

Lactinex Tablets

Lactinex Tablets contain a standardized viable mixed culture of Lactobacilli acidophilus and bulgaricus. They are indicated in reestablishing normal physiology in gastrointestinal disturbances, and are effective in the treatment of uncomplicated diarrhea. **Hynson, Westcott & Dunning, Inc., Dept. MH, Baltimore 1, Md. (Key No. 891)**

Biomydrin

Biomydrin is a nasal solution that is isotonic, antiallergic, antibacterial and decongestant. It is a stable solution with a pH of 6.2 indicated for therapy in a wide range of common upper respiratory disorders and allergic conditions. **The Nepera Chemical Co., Inc., Dept. MH, Yonkers, N. Y. (Key No. 892)**

(Continued on page 252)

Patient comfort is prompt



Prompt, continued control of pain is one reason its "FOILLE *First in First Aid" in treatment of* BURNS, MINOR WOUNDS, LACERATIONS, ABRASIONS *in offices clinics, hospitals.*

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SOLUTION INTRAMUSCULAR

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HYPERTENSIVE CRISES

Given in proper dilution slowly by vein, Solution Intravenous Veriloid usually reduces both the systolic and diastolic blood pressures in a matter of minutes—entirely within the control of the physician. This valuable emergency drug frequently proves to be a life-saving measure. Contains 0.4 mg. of alkavervir (mixed Veratrum viride alkaloids) in 0.25 per cent acetic acid solution.

The dependable hypotensive response produced by Solution Intramuscular Veriloid quickly relieves the distressing symptoms of critically elevated blood pressure. Injected deep into a muscle, a single dose of Solution Intramuscular Veriloid leads to a significant fall in blood pressure. Attaining its maximum effect in 60 to 90 minutes, this drop persists for 3 to 6 hours. Through repeated injections, the tension may be kept depressed for many hours or even days if necessary.

During this period, continuous relief is afforded the patient. Thereafter, suitable oral medication should be given in an effort to maintain the relief so achieved.

Solution Intramuscular Veriloid is widely indicated in all types of severe hypertension:

- hypertensive states accompanying cerebral vascular disease
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- toxemias of pregnancy
- pre-eclampsia
- eclampsia

Solution Intramuscular Veriloid, providing 1.0 mg. of alkavervir (mixed Veratrum viride alkaloids) per cc. of isotonic buffered aqueous solution incorporating one per cent procaine hydrochloride, is supplied in 2 cc. ampuls in boxes of 6.

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An Original Riker Research Product

What's New . . .

Product Literature

• **"Sterile Instruments for the Hospital"** is the title of a quick reference bulletin containing essential data on the latest technics for providing safe, rapid and effective washing and sterilizing of instruments. **Bulletin C-112-NR** issued by American Sterilizer Co., Erie, Pa., gives full information on the complete line of instrument sterilizers manufactured by the company. In addition the bulletin gives recommended layouts for the Central Instrument Preparation Room, the Instrument Clean-Up Room and for Sub-Sterilizing Facilities between operating rooms. **(Key No. 893)**

• **"Continuous Microfilm Enlargement Service"** is the title of a folder describing how to get extra copies of original records and obtain greater use of microfilmed records. **Booklet #BDS-3 Rev. 1** is offered by Remington Rand Inc., 315 Fourth Ave., New York 10. **(Key No. 894)**

• **Penfield Fully Automatic Mono-Column Demineralizers** are described in a new catalog sheet released by Penfield Mfg. Co., Inc., 19 High School Ave., Meriden, Conn. Detailed description of parts, sample specifications and performance data supplement the diagrams of the product. **(Key No. 895)**

• **"Safety Calls for Mobilfirewalls"** is the title of a new brochure released by Virginia Metal Products Corp., 1112 First National Bank Bldg., Pittsburgh 22, Pa. The brochure gives information on the Underwriters' approved one-hour movable steel partition, the VMP Mobilfirewall. Included are detailed drawings and descriptions of the Underwriters' test and information on this fire partition designed for storage areas and other special areas in institutions of all types. **(Key No. 896)**

• **"Vertical Transportation by Otis"** is the title of the 1953 general catalog issued by Otis Elevator Co., 260 Eleventh Ave., New York 1. The complete line of Otis equipment and services is described, including sections on hospital and passenger elevators, dumbwaiters, elevator modernization, freight elevators and maintenance programs. **(Key No. 897)**

• Many new items not before listed are described and illustrated in the new 56 page catalog released by the American Medical Specialties Co., Inc., 12 E. 12th St., New York 3. The over 600 items featured include **metal and rubber specialties for hospitals, laboratories and clinics.** The catalog has a simplified cross index system for easy, fast finding of any item. **(Key No. 898)**

• **"Faster Food and Dish Handling with Lamson Trayveyors"** is the title of a new catalog issued by Lamson Corporation, Syracuse 1, N. Y. The two color, 24 page booklet, Bulletin 749, was developed to illustrate the advantages to be derived from the installation of the Trayveyor for institutional food handling. **(Key No. 899)**

• A complete unit for smaller steam generating plants is described in **Bulletin WC-110** released by Graver Water Conditioning Co., 216 W. 14th St., New York 11. This new development is a compact "package type" heater, completely equipped with all accessories, for smaller boiler plants. It is of the effective spray-tray type with a vent condenser of the internal type for maximum compactness. **(Key No. 900)**

• Primary functions of **Mississippi Glass** products are carefully detailed in the new **Catalog No. 53** issued by Mississippi Glass Co., 88 Angelica St., St. Louis 7, Mo. The catalog is designed to aid administrators, architects, engineers and decorators in their selections of Mississippi glass products. Light distribution charts of each pattern are presented and technical information on Coolite, Heat Absorbing and Glare Reducing Glass as well as tabular data on the complete line are included. **(Key No. 901)**

(Continued on page 254)

PROJECTING

"OVER THE DOOR" ROOM NUMBERS

. . . now solve your open door problem.



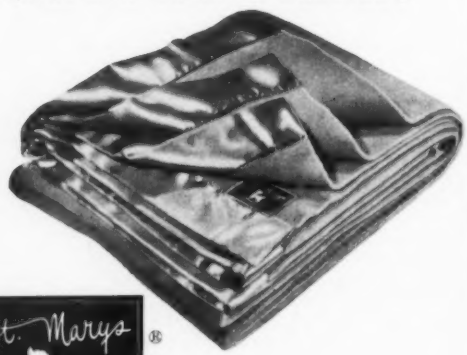
Plastic number plates, projecting over the doors of hospital rooms also make it easier to find the rooms without confusion or delay because the numbers are clearly visible for considerable distances down the hall. Actual size of number plate is 2" x 5" with large, bold 1½" high white numbers on both sides with a choice of colored backgrounds. Also available in flat door plate style.

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ENDURO *Cleanability* cuts kitchen man-hours

Kitchen equipment made of Republic ENDURO Stainless Steel actually takes less time to clean. And that means *extra time* left for doing the work necessary to maintain high service standards . . . without adding to your overhead.

Take the kitchen shown here. Everything you see is stainless including the back wall. With a warm rinse and a wipe, unskilled help can clean it . . . and keep it clean. If it's necessary to use a standard cleaning compound, ENDURO's original lustre still comes up shining. That's because it's solid stainless steel. No plating to rust or chip. Nothing on its smooth surface that gives contaminants a foothold.

ENDURO lasts. It stubbornly resists rust and corrosion. Heat stain, too. It has no effect on foods, nor do foods affect ENDURO. It's chemically inert. And it stands up under daily bumping and banging for years, because it's a tough alloy steel.

Fabricating ENDURO is easy. You can polish it, buff it, and end up with a shiny, glassy-smooth surface. And you can use it for almost every piece of equipment in the kitchen. Republic metallurgists will be glad to work with you and your equipment suppliers to show you where you can best use ENDURO. If you're planning modernization or expansion, write to:

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What's New . . .

• The complete line of Westinghouse fans for 1953 is illustrated and described in the new **Fan Catalog 3FN-0301** issued by Westinghouse Electric Appliance Division, 653 Page Blvd., Springfield 2, Mass. **(Key No. 902)**

• The **1953 Edition, Catalog 90, Sanymetal Toilet Compartments** is now available from The Sanymetal Products Co., Inc., 1701 Urbana Rd., Cleveland 12, Ohio. Detailed engineering information and architectural specifications on shower stalls and cubicles are provided in the new catalog which provides a selection chart of types of compartments. Both ceiling-hung and floor-support types are shown and a color chart with color chips offers selection of 22 colors. One page describes and illustrates Sanymetal Toilet Compartment Hardware. **(Key No. 903)**

• How to control space with flexible interiors is shown in a 48 page manual, **Catalog No. 53,** issued by the Mills Company, 975 Wayside Road, Cleveland 10, Ohio. The book is based on thirty years of experience in the design, manufacture and installation of movable walls in commercial, industrial and institutional buildings and contains numerous installation and construction photographs, detailed construction drawings and complete specifications data. **(Key No. 904)**

• A complete catalog of furniture, equipment and accessories for the modern laboratory is being made available by Metalab Equipment Corp., Hicksville, L. I., N. Y. The comprehensive 180 page book illustrates and describes the Metalab line and contains technical information and data for planning new laboratories and modernizing old ones. The free engineering and design services available to users of Metalab equipment are discussed in the **Manual #4B.** Other subjects covered include counsel on utilization of new equipment and present facilities, ease and coordination of laboratory operation, location and types of plumbing and electrical utilities, ventilation, lighting and functional design. Photographs of actual laboratories are used as illustrations. **(Key No. 905)**

• The **1953 catalog of Saunders Books** for the Medical, Dental, Nursing and Allied Professions is now available from W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. The booklet is fully indexed by subjects as well as by authors. **(Key No. 906)**

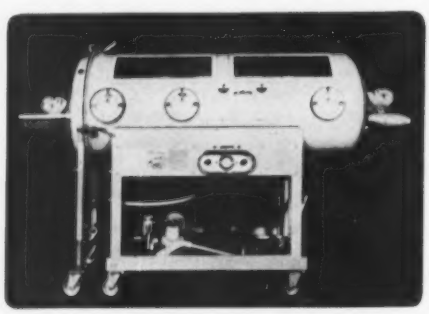
• Many newly introduced instruments and equipment for research, development and control laboratories are illustrated and described in the new 16 page **catalog** released by Schaar & Co., 754 W. Lexington St., Chicago 7. **(Key No. 907)**

• Present day drug manufacturing is pictured in a 25 minute sound, color 16 mm. film available from Eli Lilly & Co., Indianapolis 6, Ind. Entitled **"In These Hands,"** the movie is available for group showing and outlines the progress of a new drug through research, development and clinical trial while depicting modern pharmaceutical, biological and antibiotic production technics. **(Key No. 908)**

• Fifty years of service to the hospital and institutional fields are behind the **Midland Approved Hospital Products** listed in a new folder released by Midland Laboratories, Dubuque, Iowa. Surgical soaps, disinfectants, floor maintainers, liquid surgical soap dispensers, dishwashing compounds, deodorant products, scrubbing and polishing machines, vacuum cleaners and mops are among the products listed in the folder which commemorates the company's anniversary year with the slogan, "Quality—Service —Over 50 Years." **(Key No. 909)**

• Information on various types of **Constant Temperature Equipment** is given in **Bulletin 5B** issued by Central Scientific Co., 1700 Irving Park Rd., Chicago 13. The 48 page booklet contains data on ovens, incubators, water heaters and thermoregulators, including details of their construction and operation. **(Key No. 910)**

(Continued on page 256)



LEARN WHY DRINKER-COLLINS DUPLEX GIVES DOUBLE VALUE

Not every hospital can afford two respirators—but if you specify a Drinker-Collins Duplex, you will have the equivalent of two respirators at the price of only one. One Drinker-Collins Duplex can treat TWO children in an emergency and save a second life while another machine can be obtained later.

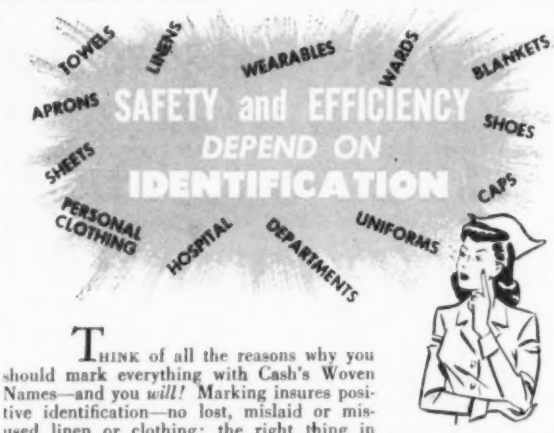


NEW FREE BOOKLET

Printed in four colors it pictures the important features of the Drinker-Collins Duplex Respirator. Advantages of the sloping front, positive pressure breathing attachment and all other accessories for patient comfort and easier nursing care are pictured and described. The new juvenile model is also shown. You'll save this 12 page booklet, for it shows the very latest developments in Iron Lung construction and design.

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Specialists in Respiration Apparatus
555 HUNTINGTON AVE., BOSTON 15, MASS.



THINK of all the reasons why you should mark everything with Cash's Woven Names—and you *will!* Marking insures positive identification—no lost, mislaid or misused linen or clothing; the right thing in the right place; fewer arguments; less danger of contamination; protection for patients, nurses, doctors, hospitals; greater efficiency and economy. The name of hospital or personal owner woven into a Cash's Name Tape guards your belongings permanently.

Cash's Names stand boiling, won't run or fade. Easy to attach with thread or Cash's NO-SO Boilproof Cement (25c a tube.)

Personal Name Prices
6 Doz. $2.75 12 Doz. $3.75
9 Doz. $3.25 24 Doz. $5.75

Ask your Dept. Store or write us your requirements.

Cash's WOVEN NAMES

SOUTH NORWALK 12, CONNECTICUT
or 112 WEST NINTH ST., LOS ANGELES 15, CALIF.

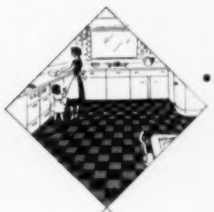


What Are YOUR Flooring Needs?

...You're sure to find what you're looking for in the TILE-TEX Line!

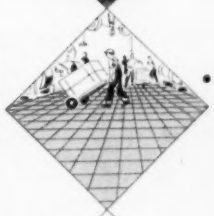
Choose from 4 distinct floor tile products; available in over 80 colors plus an exceptional selection of sizes and thicknesses. They can all be installed on or below grade—over wood or concrete.

Do you want a vinyl tile—the ultimate in resilient flooring? One that offers exceptional beauty . . . a choice of 28 bright, rich colors? A greaseproof tile that resists acids and alkalis? Do you want a floor that's exceptionally easy to clean and keep clean—that never requires waxing?



...You can't beat FLEXACHROME* VINYL PLASTIC-ASBESTOS FLOOR TILE!

Do you want a greaseproof tile that's made especially for industrial areas subjected to grease and oil abuse? A *heavy-duty* floor that takes plant traffic, lubricating oils, food and kitchen greases? Do you want a tile that withstands rolling friction including a reasonable amount of trucking . . . that brightens up drab interiors and has a safe, sure walking surface?



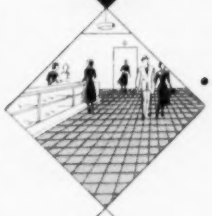
...Your best bet is TUFF-TEX* GREASEPROOF INDUSTRIAL FLOOR TILE!

Do you want a light-colored, greaseproof floor tile with high resistance to food, greases, and oils? Colors that have exceptionally high light reflectivity? Do you want a floor that's economical to maintain—that requires only the usual sweeping, periodic washing, and occasional water-waxing?



...There's nothing like VITACHROME† GREASEPROOF RESILIENT FLOOR TILE!

Do you want a low-priced, high quality asphalt tile? One that combines beauty with durability, minimum maintenance, and long service? Do you want a tile that has a long established reputation for satisfactory performance?



...Your answer is TILE-TEX* ASPHALT FLOOR TILE!

Do you want a flexible tile wall covering—one that's ideally suited for commercial, industrial, or residential wainscoting and walls. A greaseproof wall covering that resists acids and alkalis. Do you want a wall that never needs painting or redecorating and is easy to keep clean? . . .



...Nothing compares with MURA-TEX* PLASTIC-ASBESTOS WALL TILE!

See your Tile-Tex Contractor . . .

listed in your classified telephone directory for complete information. Or write:

THE TILE-TEX DIVISION, *The Flintkote Company, 1234 McKinley Street, Chicago Heights, Illinois.*

Tile-Tex—Pioneer Division, *The Flintkote Company, P. O. Box 2218 Terminal Annex, Los Angeles 54, Calif.*

The Flintkote Company of Canada, Ltd., *30th Street, Long Branch, Toronto, Canada.*

†Trademark *Registered Trademark, The Flintkote Company

TILE-TEX... *Complete* Flooring Service

What's New . . .

• Comprehensive technical data for simplifying choice of proper air diffusers in air conditioning systems are given in the new 64 page **Selection Manual #45-1953** issued by Anemostat Corporation of America, 10 E. 39th St., New York 16. This third revised edition contains a complete new section on Duct Take-off Design and is illustrated with photographs, tables on performance data and case examples. It shows how proper locations and correct number of required units are determined. **(Key No. 911)**

Book Announcement

Berman and Beckett, "Sterilization and Disinfection," handbook for nurses, $2.50. **A-T-I Publishing Co., Dept. MH, 11471 Vanowen Blvd., North Hollywood, Calif. (Key No. 912)**

Suppliers' News

Bauer & Black, manufacturer of medical and surgical supplies, announces the opening of **new and enlarged research laboratories** on April 29, at its plant at **2500 S. Dearborn St., Chicago 16.** The completely redesigned laboratory building has been attractively decorated, providing pleasant surroundings for the research scientists. Special facilities are provided in the new laboratories for radioisotope research in the study of suture absorption and related problems. Enlarged facilities are now available for research in the biological sciences, including bacteriology, physical pathology, histology and biochemical research. Special sterile rooms for handling pathological organisms and for conduction sterilization research are included as is a new animal hospital for clinical testing of the products. Consideration has been given to the study of adhesion forces and the structure of the new plastic films and plastic adhesive tape products recently introduced by the company.

The Mennen Company, manufacturer of preparations for infant care and men's toiletries, announces the opening of its **new plant** in Morristown, N. J. Special ceremonies for "Welcome Mennen Week," May 11 to 16, were held in Morristown and neighboring communities as well as on radio programs, to welcome the 74 year old company in its new plant.

Merck & Co., Inc., Rahway, N. J., manufacturing chemists, announces the opening of the **new research center** of the **Merck Institute for Therapeutic Research** on May 2. Opening of the new building completes the four-year construction program which makes the Institute a completely modern therapeutic research center. The Merck Institute was founded in 1933 to investigate the mode of action and therapeutic efficacy of new drugs and chemicals. Activities of the Institute cover research on fundamental problems, investigations into the pharmacology and toxicology of specific drugs and chemicals, assay of chemicals and drugs for potency and safety, and the development of methods and the design of instruments needed for these purposes. The new research center was started in 1948 and includes the Chemotherapy Building, the Poultry Nutrition Building and the new Laboratory and Administration Building just opened, which completes the center.

Pittsburgh Corning Corp., manufacturer of glass blocks and Foamglas, announces removal of its offices from **307 Fourth Ave.,** to **One Gateway Center, Pittsburgh 22, Pa.**

G. P. Putnam's Sons, book publishers, announces removal of its offices from **2 W. 45th St.** to **210 Madison Ave., New York 16.**

John Sexton & Company, 500 N. Orleans St., Chicago 90, manufacturer and distributor of food products for the institutional field, announces the purchase of **The Columbia Conserve Company of Indianapolis,** a food processing concern with 72 years of experience. The purchase includes all the plant facilities previously operated by Columbia and which have been almost entirely rebuilt and equipped with modern machinery and equipment in recent years. Additional improvements will be made in the Columbia property by Mr. Sexton and a new Sexton branch sales office and distributing warehouse will be opened on the property to handle service to Sexton customers in Indiana and Kentucky.

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 848 Multifit Interchangeable Syringe
- ☐ 849 Bolta Wall-Tile and Rolls
- ☐ 850 Utility Tray and Cart
- ☐ 851 Mark 313 Deep Fryer
- ☐ 852 Stryker Cast Spreaders
- ☐ 853 Lotocreme Massage Lotion
- ☐ 854 Kem-Krete Coated Block
- ☐ 855 Lawn Care Attachments
- ☐ 856 Quick-Change Mop
- ☐ 857 Room Air Conditioner
- ☐ 858 Finger-Flite Typewriter
- ☐ 859 1-Minute X-Ray
- ☐ 860 Craig Universal Headrest
- ☐ 861 Magnesium-Front Cassette
- ☐ 862 Topper Pads
- ☐ 863 Venetian Blind Laundry
- ☐ 864 Chemical Resisting White
- ☐ 865 Automatic Vegetable Peeler
- ☐ 866 Laboratory Hot Plate
- ☐ 867 Spacemaster Folding Doors
- ☐ 868 Sof-T-Septic for Diapers
- ☐ 869 Bedside Lamp
- ☐ 870 Aluminum Hardware
- ☐ 871 Poly-Krome Asphalt Tile
- ☐ 872 Institutional Incinerator
- ☐ 873 Disposable Bed Pads
- ☐ 874 Adding Machine
- ☐ 875 Hood Type Oxygen Tent
- ☐ 876 Hot Food Serving Table
- ☐ 877 Biological Tray
- ☐ 878 Fertileze Plant Food
- ☐ 879 Multiple Beverage Dispenser
- ☐ 880 Swing-Bac Divan
- ☐ 881 Child's Bath Mitts
- ☐ 882 Plastic Lung
- ☐ 883 Wooster Threshold
- ☐ 884 Indicator Chart File
- ☐ 885 Aluminum Folding Bed
- ☐ 886 Mebaroin
- ☐ 887 Expandex
- ☐ 888 Gantricillin
- ☐ 889 Icotest Reagent Tablets
- ☐ 890 Mejalin
- ☐ 891 Lactinex Tablets
- ☐ 892 Biomydrin
- ☐ 893 "Sterile Instruments" Catalog
- ☐ 894 "Continuous Microfilm Service"
- ☐ 895 Penfield Demineralizers
- ☐ 896 Mobilfirewalls Brochure
- ☐ 897 "Vertical Transportation"
- ☐ 898 Metal and Rubber Specialties
- ☐ 899 "Dish Handling With Trayveyors"
- ☐ 900 Bulletin WC-110
- ☐ 901 Catalog of Mississippi Glass
- ☐ 902 Fan Catalog
- ☐ 903 Sanymetal Toilet Compartments
- ☐ 904 Catalog No. 53
- ☐ 905 Laboratory Manual No. 48
- ☐ 906 Catalog of Saunders Books
- ☐ 907 Laboratory Apparatus
- ☐ 908 "In These Hands"
- ☐ 909 "Midland Hospital Products"
- ☐ 910 Constant Temperature Equipment
- ☐ 911 Selection Manual
- ☐ 912 "Sterilization and Disinfection"

I should also like to have information on the following products

_____

_____

NAME _____ **TITLE** _____

HOSPITAL _____

STREET _____

CITY _____ **ZONE** _____ **STATE** _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Printed in U.S.A.

PREFERRED
for ICE WATER SERVICE



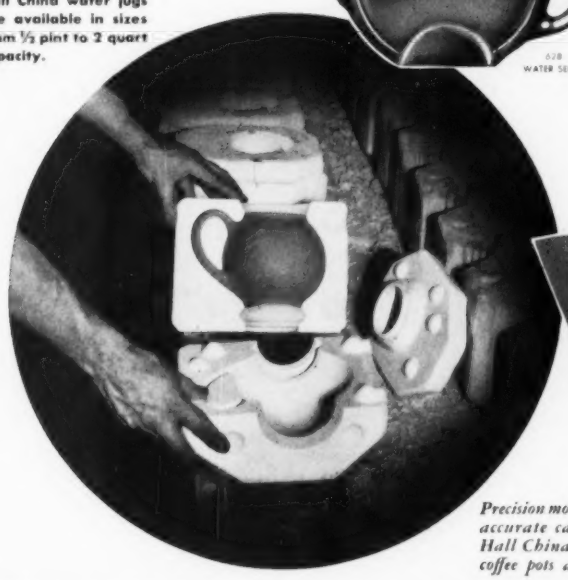
Hall China water jugs are available in sizes from ½ pint to 2 quart capacity.

Hall China water jugs are available in a wide variety of shapes for service in every type of institution. They are made of heavy, absorption-proof china by an exclusive process—which gives them extra strength and sturdiness to stand hard use . . . and a smooth surface which can be kept sparkling with a minimum of cleaning and sterilizing.

Write on company letterhead for Catalog 53, which lists almost 1,000 different Hall China items and contains a color chart of the 27 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China



Precision molds assure accurate casting of Hall China teapots, coffee pots and jugs.

HALL
Secret Process
FIREPROOF CHINA



Here is the Shower Head that's

AUTOMATICALLY SELF-CLEANING

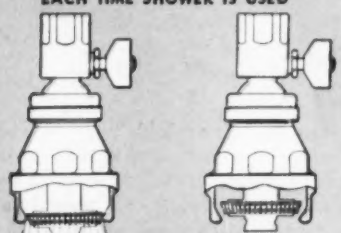
each time it's used

NO CLOGGING • NO DRIPPING

There is no shower head like the new SLOAN *Act-O-Matic.* The exclusive feature which sets it apart from all others is its *automatic self-cleaning action.* The unique spray disc moves downward into shower position when the water is turned ON. A cone-within-cone spray of maximum efficiency is delivered. When the water is turned OFF the disc is moved upward, draining the head instantly.

Because the water is completely removed, the *Act-O-Matic* SHOWER HEAD does not clog or lime up, and therefore it will not deliver irregular or distorted spray patterns. The *Act-O-Matic* is also economical in use. It saves water, fuel and maintenance service. (Institutional models available.)

THE *Act-O-Matic* Disc MOVES EACH TIME SHOWER IS USED



DISC DOWN SHOWER ON

DISC UP SHOWER OFF

OFF position opens large, free waterway permitting Automatic Self-Cleaning

SLOAN VALVE COMPANY

4350 WEST LAKE STREET

CHICAGO 24, ILLINOIS

THE SLOAN

Act-O-Matic

SHOWER HEAD



The SLOAN *Act-O-Matic* SHOWER HEAD *is a product of Sloan Valve Company, whose flush valves are in world-wide use —in buildings of every type and on ships at sea. More Sloan Flush Valves are sold than all other makes combined.*

SLOAN VALVE COMPANY
4350 West Lake St., Chicago 24, Illinois

Please send folder containing full information on your *Act-O-Matic* SHOWER HEAD to:

NAME_____

FIRM NAME_____

ADDRESS_____

CITY & STATE_____